

Purchasing Private Health Insurance through Government Health Care Programs: A Guide for States

Laura A. Tollen
Senior Analyst
Institute for Health Policy Solutions, Inc.

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About the Author

This technical assistance manual was produced for The Robert Wood Johnson Foundation's *State Initiatives in Health Care Reform* program. The *State Initiatives* program helps states improve the availability and affordability of health insurance coverage, particularly for working families. Through providing states with grants, technical assistance, workshops, and information on best practices, the program is designed to build the policy making and technical capacity of states to address their own unique health care coverage issues.

Laura Tollen is a Senior Analyst at the Institute for Health Policy Solutions, where she leads the Institute's project *Building Public-Private Financing Structures for Uninsured Kids*, funded by the David and Lucile Packard Foundation. Under this project, Ms. Tollen provides technical assistance and policy analysis to states and purchasing groups seeking to use public funds to buy into private, employer-based health insurance for children and families. Her other areas of expertise include managed care purchasing, rates, risk adjustment, and Medicaid and Title XXI financing issues.



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I. Introduction

In recent years, major changes in America's welfare laws and publicly-funded health care programs have brought about an unprecedented wave of state-level health care reform activity. With the passage of several key pieces of federal legislation, health care officials across the country are looking for innovative ways to take advantage of new funding and new programs that extend insurance coverage to previously uninsured populations. These federal changes have significantly increased the likelihood that people eligible for publicly funded health care programs will be employed (or will be dependents of employed persons) and will, therefore, have access to private, employer-based insurance coverage. As a result, there is a growing recognition among states that the private sector can and should be an important partner in providing coverage to America's uninsured.

Many states currently have legislative authority to buy into private, employer-based coverage for eligible working families and/or children. Three states — Massachusetts, Wisconsin, and Mississippi — have received federal permission to implement such programs under the State Children's Health Insurance Program (Title XXI) and/or Medicaid. (The Massachusetts program has been operational since August of 1998, while the other two states have not yet begun implementation.) In addition, according to a U.S. General Accounting Office report, in 1992, eighteen states had programs that used Medicaid funds to buy into employer-based health insurance (although only three — Iowa, Pennsylvania, and Texas — had programs of significant size).¹ Finally, several states are considering programs that use state-only funds to buy into private insurance. Oregon implemented such a state-only program for families in July of 1998, and Illinois implemented a program for children in October of 1998.

Clearly, private health insurance buy-in is an idea whose time has come. This Guide for States is designed to help senior-level state health officials answer the "why" and the "how" of developing private coverage buy-in programs. **Section I** of the Guide includes an explanation of the rationale for coordination of public and private funding streams and coverage. **Section II** provides a practical and detailed summary of the major design and operational issues state health officials should consider in designing such programs, whether the funding source is Medicaid, Title XXI, state-only funds, or a combination. Each chapter under Section II includes a *Chapter Highlights* summary and a number of state examples. **Section III** provides a list of resources for states wishing to learn more.

A. Why Is the Time Right for Private Coverage Buy-In Programs?

While it's clear that states are increasingly interested in programs that use public funds to subsidize private health insurance, the question remains: why is there so much interest in this concept *now*? For close to a decade, states have had authority to use Medicaid funds to buy into private coverage when it is available to program recipients. Such Health Insurance Premium Payment (HIPP) programs were authorized under the Omnibus Reconciliation Act of 1990. However, there are few examples of large-scale, successful HIPP programs. States that did attempt to fully develop such programs have met with a number of operational difficulties.² More generally, states' failure to aggressively implement HIPP programs may be due to the fact that, traditionally, Medicaid income eligibility thresholds have been set so low that most recipients were unlikely to be employed and, therefore, to have access to employer-based or private coverage.

This dynamic is changing, however. A number of factors, including economic trends, new federal laws, and the implementation of state coverage expansions, have come together in recent years to increase significantly the likelihood that individuals covered by public health care programs will be employed (or have an employed parent) and may have access to private insurance which they can afford.

1. ECONOMIC TRENDS

The following economics trends have contributed to the likelihood that individuals eligible for public health care programs may have access to private insurance.

- **Many low-wage workers have access to employer-based insurance.** In 1996, 43 percent of workers making \$7 or less per hour were offered health insurance by their employers.³ Among workers making \$7.01 to \$10.00 per hour, 70 percent were offered employer-based insurance. (Although offer rates rise as income rises — 86 percent of workers making at least \$15.00 per hour were offered insurance — it is still significant that many of the lowest-wage workers did have access to employer-based coverage.)
- **Poor people can't afford coverage, even when it is offered to them by an employer.**
 - While access to employer-based insurance has not declined between 1987 and 1996, take-up rates of such insurance by employees did fall during that period by 8.2 percent.⁴ Among the lowest-wage workers (those making \$7 per hour or less), the take-up rate for employer-based insurance declined from 79.7 percent in 1987, to 63.2 percent in 1996, a difference of 16.6 percentage points. (In this study, workers were considered to have “access” to employer-based coverage if the worker or the spouse was offered coverage by an employer.)
 - This decline is likely due to workers being unable to afford the employee portion of health insurance premiums. Between 1987 and 1993, health insurance premiums rose by 90 percent nationwide, while wages rose only 28 percent.⁵ As a result, jobs that used to pay enough for employees to afford their portion of health insurance premiums may no longer do so.
- **Even when workers can afford employer-based coverage for themselves, they may not be able to afford it for their dependents.** Data from the Medical Expenditure Panel Survey show that in 1996, about 22 percent of uninsured children had at least one parent covered by an employer plan.⁶ An additional 15 percent of uninsured children had at least one parent offered employer-based coverage who did not take it. While it is not known how much, or whether, such employers contributed to the extra cost for dependent coverage, it is clear that many workers were not choosing to cover their dependents through the employer-based plan.

2. NEW FEDERAL LAWS AND STATE COVERAGE EXPANSIONS

With the passage of major federal legislation in 1996 and 1997, poor working families who cannot afford private coverage have become eligible for publicly funded health insurance. The relevant new federal laws are: Section 1931 of Title XIX, included under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996; and, Title XXI of the Social Security Act (1997), creating the State Children's Health Insurance Program (CHIP). In addition, more states have begun implementing coverage expansion programs under Section 1115 of the Social Security Act or as state-only programs.

Section 1931

Prior to the 1996 passage of PRWORA, Medicaid eligibility for families was largely tied to receipt of Aid to Families with Dependent Children (AFDC), which included strict income and asset requirements. Because the income requirements for welfare and Medicaid were so low, income from employment would easily have disqualified a person from these public programs. Accordingly, it was unlikely that many adults covered by Medicaid were employed. However, PRWORA may increase the likelihood that Medicaid recipients will have access to employer-based coverage by “de-linking” Medicaid and welfare eligibility and by permitting states to modify the income and asset thresholds under which individuals may qualify as “Medicaid-only” eligibles.⁷

States’ new authority to modify Medicaid income and asset eligibility levels is provided under Section 1931. Under this provision, states may disregard certain amounts of employment income in determining Medicaid eligibility, thus increasing the likelihood that working families may qualify. More detailed information about the mechanics of Section 1931 is included in Appendix A.

Title XXI – The State Children’s Health Insurance Program

A second law that has contributed to a renewed focus on private coverage buy-in programs is Title XXI of the Social Security Act, creating the CHIP program. The CHIP law allows states to raise the income level at which children may qualify for publicly funded coverage. Few states provide Medicaid coverage for families with incomes above 133 percent of the federal poverty level (FPL). In contrast, CHIP programs may serve children with family incomes up to 200 percent FPL (or 50 percentage points above the state’s highest applicable Medicaid income level, whichever is higher). Children at these higher income levels are more likely to have a working parent with access to employer-based or individual insurance. The CHIP law also allows states to apply to the Health Care Financing Administration (HCFA) for a “variance” that permits the purchase of *family* health insurance through a group plan that includes coverage for the children targeted by CHIP (provided that the purchase of such family coverage is cost-effective).⁸ Although only two states, Massachusetts and Wisconsin, have received such a variance from HCFA so far, this provision gives states another reason to consider coordination with employer-based coverage, as employers are the likely source of such family coverage.⁹

Other Coverage Expansions

While Section 1931 and the CHIP law have given states new opportunities to expand coverage to individuals at higher income levels (who are, therefore, likely to have access to private coverage), many states had already implemented such coverage expansions under previously-existing laws.

- **Section 1115 of the Social Security Act.** This Medicaid provision allows states to apply to HCFA to waive certain Medicaid program requirements for purposes of conducting large-scale demonstration projects. One type of Section 1115 waiver permits states to modify Medicaid eligibility rules. Some states have used this waiver to expand their Medicaid programs well beyond the traditional eligibility groups. States that have used Section 1115 waivers in this way include Alabama, Arizona, Arkansas, Delaware, Florida, Massachusetts, Minnesota, Ohio, Oregon, Rhode Island, Tennessee, and Vermont.¹⁰
- **State-Only Programs.** A number of states have used state-only funding to provide health care services or insurance coverage to individuals with incomes that make them ineligible for the Medicaid program. One of the better-known state-only programs is the Washington Basic Health Plan, which provides subsidized coverage for a small number of children under 200 percent FPL who do not wish to enroll in Medicaid, subsidized coverage for adults below

200 percent FPL, and unsubsidized coverage for adults and children above 200 percent FPL. State-only programs for families and/or children have also been established in Oregon, Massachusetts, New York, Pennsylvania, California, New Jersey, and Florida.¹¹

B. What are the Public Policy Objectives?

Economic trends, new laws, and state coverage expansion programs have increased the likelihood that individuals in public health care programs may have access to private coverage, thus heightening states' interest in private coverage coordination initiatives. State officials may wonder, however, what public policy objectives are served by using public funds to buy workers and families into private coverage. Although the circumstances of each state are different, there appear to be several major objectives that are often cited by states considering a private coverage buy-in. These objectives include:

- **Expanding Coverage by Maximizing Limited Public Funds.** States can maximize the value they receive from tight Medicaid, CHIP, and state-only budgets by leveraging private funds that are currently used to purchase coverage for public program eligibles. For example, assume a former welfare recipient obtains a job under which benefits are available, with the employer contributing 60 percent toward family coverage. However, the newly employed person and her family are also eligible for Medicaid. Rather than paying for 100 percent of the family's coverage under the Medicaid program, the state could take advantage of the employer's 60 percent contribution by buying into the employer's plan. States are seeking ways to share the cost of coverage with employers, rather than using limited public funds to substitute for dollars employers and employees are already spending (or are willing to spend) on coverage.
- **Insuring Low-Income Adults to Support Work.** Many states are pursuing private coverage buy-in programs as part of a larger strategy of encouraging and supporting work for low-income adults. Prior to the passage of the 1996 welfare reforms, many welfare recipients hesitated to return to work for fear of losing Medicaid coverage for themselves or their children. Although welfare reform has made it easier for low-income workers to qualify for Medicaid, such Medicaid coverage is time-limited. At some point, many low-income adults will still find that they must buy health insurance on their own. Private coverage buy-in programs provide subsidies for such adults who may be unable to afford the employee portion of an employer-based plan. By providing subsidies, states strengthen employees' ties to their employers and, more importantly, make it easier for low-wage employees to remain in the workforce.
- **Covering More Children.** A recent study by Thomas Selden and colleagues indicates that in 1996, 4.7 million children were eligible for, but not enrolled in, Medicaid.¹² The Medicaid take-up rate for children who also received AFDC (cash assistance) was almost 75 percent, compared to only 59 percent for children receiving Medicaid through aid categories not linked to cash assistance. The study's authors suggest that the take-up rates are higher for families of Medicaid-eligible children in the cash assistance categories because such families are often enrolled in Medicaid when they apply for cash assistance. In contrast, families of Medicaid-eligible children in the non-cash-assistance categories may be less aware of their eligibility. The welfare reforms of 1996 have further "de-linked" Medicaid and cash assistance eligibility. As a result of this law change, increasing numbers of children are eligible for Medicaid but not for cash assistance. States are seeking new means of reaching such Medicaid-eligible children who can no longer be reached through the old channel of the local

welfare office. Some state officials believe that reaching such children through their parents' place of employment and coordinating Medicaid (or CHIP) coverage through the employer-based health plan is one means of covering the targeted children.

- **Minimizing Stigma.** Some families may be reluctant to enroll in a public program such as Medicaid or CHIP due to perceived stigma regarding participation in a government program. The same families may be more willing to accept subsidies if they can use the funds to remain in an employer-sponsored or individual plan.¹³ While the existing information about stigma associated with Medicaid is largely anecdotal, it is clear that many more people are eligible for Medicaid than are enrolled. The perception of stigma, second-rate benefits, and poor treatment at the hands of providers may contribute to such failure to enroll. Many of these concerns would likely be ameliorated if families were able to use government subsidies to enroll in mainstream, employer-based plans.
- **Keeping Families Together Under a Single Insurance Plan.** Under the CHIP and Transitional Medicaid programs, there will likely be a number of families in which one or more parent has employer-based coverage, while the children obtain coverage through a public program. This type of fragmentation of the family's coverage can be a barrier to obtaining care and appropriately using services. Programs that use public funds to buy into employer-based coverage provide a means of keeping all the members of a family together under a single insurance plan.

While the author made every reasonable attempt to provide accurate information, the opinions expressed in this Guide do not necessarily reflect the current official positions of the federal Health Care Financing Administration (HCFA). The federal agency did not review this Guide. Because of the uniqueness of each state's circumstances and the complexity and changing nature of federal requirements, states are advised to consult HCFA and legal counsel before designing a buy-in program involving federal funds.

II. Developing a Private Coverage Buy-In Program

Although many states are interested in developing private coverage buy-in programs, there are few available “how to” resources. This section of the Guide outlines a number of issues that states should address in the design of a private coverage buy-in program and provides concrete alternatives for solving operational problems. Where possible, examples from existing programs are included. The Guide is divided into sections on **Program Design** and **Program Operations**.

A. Program Design

States should first consider these general design issues, as decisions made in these areas will impact decisions concerning operations. The design issues include:

- Obtaining data to build a case for a private coverage buy-in program;
- Sources of program funding: state-only versus state/federal;
- Group and individual coverage: understanding the state’s insurance market;
- Crowd-out of private coverage;
- Employers’ role and employee confidentiality; and,
- Cost-effectiveness and family coverage.

Chapter Highlights:

- To determine whether a private coverage buy-in program will support a state's public policy objectives, officials need to collect data regarding the state's target population and insurance market characteristics.
- This chapter provides an overview of the types of data states may wish to collect. Appendix B provides a summary of major data sources.

1. CONSIDER THE PUBLIC POLICY OBJECTIVES: OBTAINING DATA TO BUILD A CASE

The introduction to this Guide lists a number of public policy objectives that could be served through development of a private coverage buy-in program. Before pursuing program design, state health officials must determine whether a state's unique public policy concerns can be addressed by a private coverage buy-in program. To make this determination, health officials need data regarding the characteristics of populations that may be (or are) eligible for publicly funded health care programs. For example, health officials need to know whether, in fact, many of the state's uninsured are employed and whether they have access to employer-based insurance. (If not, a private coverage buy-in program may not produce enough "bang for the buck" in terms of the number of people it can reach relative to its administrative cost.) In general, states need two types of information:

- Demographic information about potential program eligibles; and,
- Information about the employer groups and employer-based coverage to which eligibles may have access.

A. Demographic Information

Answers to the following questions will help states develop appropriate program eligibility rules based on age, income, employment status, size of employer, etc. This information will also help states design an outreach strategy that is likely to reach the target population.

1. **How many (and what percentage of) adults at various percentages of the federal poverty level are employed?**
2. **How many (and what percentage of) children at various percentages of the federal poverty level have an employed parent?**
3. **Of working adults, how many (and what percentage) have access to employer-based coverage?**
4. **What percentage of workers in the targeted income range are employed by small businesses (those with 50 or fewer employees)? What percentage work for medium-sized and large businesses?**
 - The answers to these questions may help states develop marketing materials or otherwise target employers who are likely to employ program eligibles.
5. **To what extent do workers in the targeted income range work for a limited number of large employers? (This may be the case in smaller states, where a private company or the government may employ a significant portion of the state's population.)**
 - As above, this information will help states target firms likely to employ program eligibles.

B. Information about the Employer Group and Employer-Based Coverage

Because private coverage buy-in programs create an interface between public programs and private health insurance, it is important for public program officials to have basic information about the private health insurance market in their state. For example, states will need to know what kind of private coverage is generally available to low-income individuals and what such coverage costs. They will also need to know what companies sell private coverage in the state and how such companies price their products. Other important questions about the private insurance market include:

Program Design Question:

What is the target population? Who is likely to be low-income and have access to private insurance?

Funding source restrictions:

Title XXI*:

■ Children through age 18 only, but other family members may be covered if cost-effectiveness is maintained.

■ Family income must be below 200% FPL (or 50 percentage points higher than highest Medicaid level).

Medicaid:

■ Restrictions depend on presence of Section 1115 waiver or Section 1931 expansion

Demographic information:

■ States should gather data to determine characteristics of low-income individuals who may have access to private insurance. What are their ages, incomes, employment status, size of employer, etc.

* Restrictions apply in all cases in which Title XXI funds are used, whether the Title XXI program is a Medicaid look-alike or a separate Children's Health Insurance program.

1. **What are typical employer contributions toward coverage in the state? How much (or what percentage of total premium) do employers pay for employee-only and dependent coverage?**
 - This information will allow states to develop rules regarding minimum employer contributions (i.e., how much an employer must contribute toward coverage, if at all, in order for the state to provide a subsidy).
2. **To what extent do employers tend to offer coverage from a limited number of large insurance carriers in the state? Who are these carriers? Is there any overlap among the carriers with the largest private market share and the carriers that serve the Medicaid managed care program, the Title XXI program, the state employees, or other public groups?**
 - To the extent that a limited number of carriers sell coverage to many employers and/or to the state, buy-in program officials may target such carriers as potential partners in program administration.
3. **To what extent is employer-based or individual coverage sold through large brokerage houses, chambers of commerce, or formal purchasing cooperatives?**
 - The existence of such entities, which purchase coverage on behalf of many groups and employers, may provide states with some economies of scale in administering a buy-in program.
4. **What types of benefit plans are most frequently purchased by employers and individuals? What are the covered services and cost-sharing requirements?**
 - This information will help states determine the extent to which commonly purchased private insurance can provide a desired (or required) level of benefits and cost sharing and, consequently, whether the buy-in program will need to supplement private insurance in any way.
5. **How do insurance carriers selling to groups and individuals price their products? What are the state's insurance rating rules?** ¹⁴
6. **What are insurance carriers' rules regarding when a person is permitted to join a group plan? Would determination of eligibility for a buy-in program be considered a "qualifying event?"**
 - "Qualifying events" are events, such as the start of employment, a marriage, a divorce, or the birth of a child, that qualify an individual to join a group insurance plan at times other than during the annual open enrollment period. Under normal circumstances, an employee and his or her dependents can join his or her employer's plan only at open enrollment or following a qualifying event. If carriers will not consider eligibility for a subsidy program a "qualifying event," states may be forced to wait several months, until the next open enrollment period, before they may cover a person through a private coverage buy-in program.

Unfortunately, the answers to these important questions are not likely to be found in a single place. Appendix B provides a summary of some of the most useful sources of relevant data, the types of questions different data sources may be able to answer, and how to access the information. Where possible, direct web-site links are provided. In many cases, states will need to perform basic statistical analyses using software programs such as SAS or SPSS in order to obtain the information they need.

Note that many national databases do not include large enough state-level samples to provide reliable results at that level. States may find it necessary to commission their own surveys, or they may have access to studies conducted by local researchers. For example, in its Section 1115 demonstration waiver application, Massachusetts used data from a survey conducted by the Harvard School of Public Health.¹⁵

2. SOURCES OF FUNDING: STATE-ONLY AND STATE/FEDERAL PROGRAMS

An important issue for states, and one that will impact nearly every aspect of program design, is the question of funding source. A private coverage buy-in program may build off of state efforts to extend coverage through Title XXI or Medicaid (under Section 1931 or Section 1115). While the inclusion of federal funds may result in a larger program budget, federal funds are more restricted in their use than are state funds.

A. Restrictions on the Use of Title XXI Funds

On February 13, 1998, HCFA issued a letter to state health officials in which the federal agency provided guidelines for states that wish to use Title XXI funds to buy into employer-based coverage. This letter is included as Appendix C.¹⁶ While these are guidelines and do not have the binding force of regulations, they do provide an indication of the direction HCFA is likely to take in issuing regulations. Later sections of this Guide provide information on ways states can design programs that are consistent with these guidelines. Under the guidelines, states may use Title XXI funds to buy into employer-based coverage if the following conditions are met:

1. Children receiving a subsidy toward employer-based insurance may not have been covered by an employer-based plan for at least six months.

- ❑ This guideline is intended to prevent “crowd-out,” the phenomenon in which families and/or employers substitute the public subsidy for funds they are currently using to purchase insurance. Although this type of substitution is a concern for public programs in general, HCFA believes that the risk of substitution is greater under a private coverage buy-in program.
- ❑ This type of “look-back” period (when the State “looks back” to check for previous coverage) is not required for children joining the Title XXI program in general, nor for individuals joining Medicaid.

2. For a child to receive a subsidy toward employer-based insurance, the employer must contribute at least 60 percent of the cost of family coverage.

- ❑ HCFA chose 60 percent as the minimum contribution because this is the median employer contribution toward family coverage nationwide. The goal of this requirement is to prevent employers from lowering their contributions toward coverage because they know employees have access to a government subsidy.
- ❑ HCFA has indicated that it will consider a lower level of employer contribution if:
 - A) state officials have data indicating that a lower level of employer contribution is prevalent in the state; or
 - B) states have additional provisions in place to prevent crowd-out of employer contributions.

3. A state’s payment for a child enrolled in an employer-based plan may be no greater than the payment the state would make for the child if he/she were enrolled in a separate CHIP plan offered by the state.

- ❑ This cost-effectiveness provision is intended to ensure that the state is not inappropriately subsidizing coverage for an adult in the family.

Chapter Highlights:

- A private coverage buy-in program may be funded with state-only or a combination of state and federal dollars.
- There are significantly more restrictions on the use of federal funds than on the use of state-only funds. In particular, states using federal funds must meet a number of requirements regarding benefits, cost sharing, and (in the case of Title XXI funds) crowd-out.
- This chapter provides an overview of the restrictions associated with the use of Medicaid versus Title XXI funding.

Program Design Question:

What is the funding source?

Options:

- Title XXI
- Medicaid
- State-only
- Combination

Issues to consider:

There are more restrictions on the use of federal funds than on the use of state-only funds. States using federal funds must meet requirements regarding benefits, cost-sharing, and (in the case of Title XXI) crowd-out.

4. Families receiving a CHIP subsidy toward employer-based coverage must apply for and receive the full premium contribution available from their employer.

- This provision is also intended to promote cost-effectiveness and to prevent state subsidies from being substituted for available or existing employer contributions.

5. States implementing an employer-based coverage buy-in program under CHIP must collect information to quantify the amount of substitution of private funds that takes place under the program.

- Although the preceding four guidelines are intended to prevent substitution of public for private funds, HCFA is (appropriately) concerned that some amount of substitution may still take place.
- To comply with this provision, states will need to collect information on average employer contributions toward family coverage, both before and after the implementation of a buy-in program. States should also collect information regarding the type and amount of prior insurance held by children participating in the buy-in program. Relevant information can be collected during the enrollment process. Additional information on average employer contributions may be available, on an *ad hoc* basis from the state's large insurance carriers (see section II(A)(1) of this Guide, *Consider the Public Policy Objectives: Obtaining Data to Build a Case*).
- HCFA intends to use these data collected by states to re-evaluate the efficacy of the other guidelines contained in the February 13 letter.

In addition to the guidelines included in the February 13 letter, there are a number of other restrictions that have become apparent through various states' negotiations with HCFA around their Title XXI state plans. These restrictions are summarized below and are also discussed in more detail in this Guide under Section II(B)(3) – Supplementing Benefits and Cost-Sharing Provisions.

6. For states to use Title XXI funds to buy into employer-based coverage, such coverage must meet the Title XXI benefits and cost-sharing requirements.

- If an employer plan does not include the level of benefits and cost sharing required by Title XXI, the state must provide supplemental benefits or cost-sharing fill-ins.

7. In providing supplemental cost-sharing fill-ins, it is not acceptable for states to ask participants to incur out-of-pocket expenses above the Title XXI cost-sharing limits and submit receipts for reimbursement.

- Even though participants would be reimbursed for expenses above the cost-sharing limits, HCFA is concerned that low-income families may not be able to make the payments up front. As a result, such families may not obtain needed services.
- States must develop alternate means of filling in cost-sharing amounts that do not involve reimbursing the participants.

B. Restrictions on the use of Medicaid Funds

Since 1990, states have been permitted to use Medicaid funds to purchase employer-based coverage under HIPP programs. While there is no single document that enumerates HIPP program restrictions on the use of Medicaid funds, it is possible to distill a number of salient restrictions based on the experience of states with active HIPP programs.

1. For states to use Medicaid funds to buy into employer-based coverage, the total package of benefits provided must meet the Medicaid benefits and cost-sharing requirements.

☐ This is a parallel requirement to item #6, above, for buy-in programs using CHIP funds. Because Medicaid benefits are fairly rich, and cost sharing is minimal or non-existent, few (if any) employer plans can provide the same standard of coverage. As a result, states must provide wrap-around benefits to bring HIPP program participants' coverage up to the same level as all other Medicaid recipients.

2. States may spend no more to subsidize a recipient's private coverage than they would spend to cover the recipient under the regular Medicaid program.

☐ This is a parallel requirement to item #3, above.

State Examples:

DECISIONS REGARDING STATE-ONLY, TITLE XXI, AND MEDICAID FUNDING

Oregon.¹⁷ States that forego federal funding have greater flexibility in designing a private coverage buy-in program. In Oregon, the state-funded Family Health Insurance Assistance Program (FHIAP) provides premium subsidies to anyone with family income under 170 percent FPL, whether group or individual coverage is purchased.¹⁸ Coverage may be purchased through an employer or from one of a number of state-approved individual carriers. The state does not have to spend administrative resources analyzing participants' private coverage and comparing it to federal standards. The state also is not required to perform cost-effectiveness calculations, such as those required under Title XXI and Medicaid. As a result of this flexibility, the FHIAP is available to a greater number of individuals than could be reached in a program bound by federal restrictions on benefits, cost-effectiveness, etc.

The downside to state-only funding is that the state must forego a large federal match. Match rates under Medicaid and Title XXI can range from 50 percent (i.e. half of all program funding is federal) to close to 80 percent.¹⁹ Oregon has budgeted \$23.4 million for the FHIAP over the next two years, with the intent of serving 15,000 to 17,000 Oregonians. If, however, the program could access Medicaid or Title XXI funds, the number of individuals served could be greater. On the other hand, as described above, the benefit and cost-effectiveness restrictions associated with the federal funds may result in fewer people being eligible for the program.

Oregon is now developing a Title XXI tie-in for the FHIAP, such that the State will be able to access federal funds for eligible children (and families when it is cost-effective) enrolled in qualified health benefit plans. State-only funds will be used for everyone else.

Rhode Island. The state of Rhode Island operates a small state-only private coverage buy-in program. Under this program, workers of child-care centers with which the State contracts are eligible for a state-only subsidy toward employer-based coverage. Because such individuals are not state employees but rather the employees of state contractors, the State cannot directly provide them with coverage. However, state officials feel a responsibility to ensure that such state contractors, many of whom are low-wage employers, can provide coverage to their employees. If a child care center is willing to pay 50 percent of the cost of employee-only coverage, the state will pay the remaining 50 percent. (No coverage is available for dependents.) Because this is a state-only program, there are no restrictions on the type of benefits that contractors can provide to their employees. To date, eight child-care centers have applied for this program.

(continued on next page)

State Examples:

DECISIONS REGARDING STATE-ONLY, TITLE XXI, AND MEDICAID FUNDING

Wisconsin.²⁰ Under the BadgerCare program, Wisconsin will use a combination of Title XXI and Medicaid funds to cover families through an employer-based insurance subsidy program and a public program. Phase II of BadgerCare will serve families with incomes between 100 percent and 185 percent FPL. Whole families, rather than just children, will be eligible under this program.

The State will receive the Title XXI enhanced federal matching rate to buy into employer-based insurance for children and their parents when it is cost-effective to do so (i.e., when the cost of covering both the children and the parents does not exceed the cost of covering just the children under the public program). When it is determined that the purchase of family coverage is not cost-effective under Title XXI rules, the State will then determine if it is cost-effective under Medicaid rules. Under Medicaid rules, it is cost-effective to buy into family coverage if it costs less than it would to enroll the whole family (as opposed to only the children) in the public program. (Recall that the whole family is eligible for BadgerCare.) If the Medicaid cost-effectiveness test is met, the state will receive the Medicaid match rate to enroll the family in private coverage. If neither the Medicaid nor the Title XXI cost-effectiveness test is met for private coverage, the family will be enrolled in the public program. In this case, the State will receive the Title XXI match rate for the children, and the Medicaid match rate for the adults.

Massachusetts.²¹ Under its MassHealth Family Assistance Program, Massachusetts is also using a combination of Medicaid and Title XXI funding to buy into employer-based coverage. Families with incomes between 150 percent and 200 percent FPL with access to employer-based coverage are eligible for the program. The state receives the Title XXI enhanced matching rate to purchase family coverage when it is cost-effective to do so (i.e., when the cost of covering both the children and the parents does not exceed the cost of covering just the children under the public or “direct coverage” program) and when the employer-based coverage meets Title XXI benefit and cost-sharing provisions. If, however, the purchase of family coverage is not cost-effective under Title XXI rules, one of two things may happen:

- If the family entered the program uninsured (i.e., they were not enrolled in any other health insurance at the time of application), the children are enrolled in the direct coverage program with the state receiving a Title XXI match rate. The parents do not receive coverage.
- If the family entered the program insured (i.e., they were enrolled in an employer-based plan at the time of application), the state makes a contribution toward the employer-based coverage up to the amount it would have paid to enroll the children directly in the public program. The family must pay any additional amount. The state receives the Medicaid match rate for its expenses in this scenario (under its Section 1115 waiver). In this case, coverage under the employer-based plan does not have to meet Title XXI benefit requirements but rather a basic benefit level defined by the state under its 1115 waiver.

3. GROUP OR INDIVIDUAL COVERAGE: UNDERSTANDING THE STATE'S INSURANCE MARKETS

States must decide whether to use public funds to buy into group coverage, individual coverage, or both. This decision will be driven largely by the status of states' insurance markets. As discussed above, in order for states to use federal funds for a buy-in program, they must be able to show that it is cost-effective to do so. Accordingly, state officials must be able to show that the private coverage is a good value. Officials designing private coverage buy-in programs should, therefore, have a basic understanding of the factors that affect the value of an insurance plan in the private market.

In most states, there are generally at least three distinct private insurance markets, each with its own set of products and rules. These markets are:

- The individual market (i.e., coverage sold to individuals not associated with an employer or other group);
- The small group market. (In some states, this category includes the self-employed, known as “groups of one,” and employer groups with from two to 50 employees. In other states, the self-employed are not considered part of the small group market but rather the individual market.); and,
- The large group market. (This category includes all groups that are not considered “small.”)

As a first step in assessing the state's insurance market, program officials should determine whether individuals likely to be eligible for the buy-in program are concentrated in the individual, small group, or large group market, or whether such individuals can be found in all markets.

Table 1 provides data from the 1996 Medical Expenditure Panel Survey, indicating the extent to which children who are likely to be eligible for Title XXI buy-in programs are associated with employer groups of various sizes.²² As the table shows, among uninsured children under age 19 who had at least one parent offered or covered by employer-based insurance, 46.6 percent were associated with small firms (those employing from two to 49 employees). An additional 34.4 percent of such children were associated with medium-sized firms (those employing between 50 and 249 employees), and 13.1 percent were associated with large firms (those employing more than 250 employees). These data indicate that at least on a national level, likely Title XXI program eligibles can be found in both the small and large group markets, although they are more concentrated in the small group market.

Table 1: Uninsured Children under Age 19 with Parent(s) Offered or Holding Employment-Based Insurance from a Private Employer, by Estimated Size of Employer, United States, 1996²³

ESTIMATED NUMBER OF WORKERS IN FIRM	NUMBER OF CHILDREN	PERCENT OF ALL CHILDREN
Not available	205,051	5.9%
2 – 49	1,624,638	46.6%
50 – 249	1,196,397	34.4%
250 or more	457,550	13.1%
Total	3,483,636	100%

Chapter Highlights:

- Private coverage buy-in programs may be designed to coordinate with coverage sold in the small group, large group, or individual insurance markets (or a combination of the three).
- State officials should understand how group and individual insurance plans are sold in their state in order to determine whether the purchase of such plans is likely to be a good value.
- This chapter presents information on the extent to which a buy-in program's target population may be found in the small group versus large group market.
- A “primer” on group and individual insurance market rating practices is provided in Appendix D.

Program Design Question:

What type of coverage will be subsidized?

Categories:

- Individual
- Self-employed
- Small employer group
- Large employer group

Issues to consider:

This decision may depend on insurance rating practices and the presence of insurance reform in various markets. The extent to which the target population is concentrated among small or large employers is also a factor.

Individual coverage is not likely to meet the cost-effectiveness test under Medicaid or Title XXI because there will be no employer contribution.

In general, states developing private coverage buy-in programs may wish to focus on group coverage. Such coverage is likely to be available to a larger number of people, and it is more likely than individual coverage to be comprehensive (increasing the likelihood that it will meet federal requirements) and to meet cost-effectiveness tests (because it is less expensive for many people). In many states, group coverage is a better value than individual coverage due to factors such as the tax treatment of contributions to employer-based coverage and the presence of small group insurance reform.²⁴

To better understand the value of the product into which they are buying, state officials considering a private coverage buy-in program should obtain information regarding standards and practices in the state's insurance markets. Officials should understand the rules that govern rating, underwriting, and the imposition of pre-existing condition waiting periods in the group and individual markets. Appendix D provides a brief "primer" on these insurance industry practices, and explains how such practices are likely to differ in group versus individual markets. The Appendix also includes an example of a state (Oregon) that provides subsidies toward private coverage purchased in either the group or individual markets. Public program officials who are unfamiliar with private insurance markets are advised to refer to the primer as a starting-place for understanding their state's markets. Further information about a particular state's rating rules and practices can be obtained from the state's Department of Insurance.

4. CROWD-OUT

In designing a private coverage buy-in program, states may wish to consider the extent to which newly-available subsidies for coverage may be substituted for private funds already in the system. The substitution of private for public dollars is known as crowd-out. When crowd-out occurs, it means that rather than covering the uninsured, a program is providing coverage to those who already had access to it. An example of crowd-out under a private coverage buy-in program is as follows:

An employer offers insurance to his low-income worker with one dependent child and contributes 60 percent of the cost of dependent coverage. The worker manages to pay the additional 40 percent of costs for his dependent's coverage. The worker and the employer then discover that the worker is eligible for a government program that pays a much higher percentage of the costs of dependent coverage, perhaps as high as 100 percent. As a result, the employer and the worker stop contributing toward dependent coverage, and the worker enrolls the child in the government program.

To the extent that the above dynamic takes place, public funds can cover fewer truly uninsured individuals. Note that in this example, not only is there crowd-out of the employee's contribution but of the employer's contribution as well. Many state and federal policy-makers are particularly concerned about the latter type of crowd-out, fearing that employers may reduce or eliminate their contributions when public funds become available. However, crowd-out of employee contributions is perhaps more common and may take place with or without crowd-out of employer contributions.

Although the prevention of crowd-out is clearly a major policy objective for many states and for the federal government, it may not be an important objective for all states. For example, states that wish to use a private coverage buy-in program to support work for low-income individuals may have as an objective the equal treatment of people in like circumstances (i.e., all low-income workers should receive assistance, regardless of prior insurance status). In each state, the relative importance of crowd-out prevention measures will depend upon the overall policy objectives of the private coverage buy-in program. (However, recall that in order to use federal Title XXI funds, states are required to implement provisions to prevent and monitor crowd-out.)

A. Does Crowd-Out Really Occur? – The Literature ²⁵

Estimates on the extent of crowd-out vary. Dubay and Kenney estimated that when states expanded Medicaid to cover pregnant women and children between 100 percent and 185 percent FPL, 14 percent of new enrollment of pregnant women and 17 percent of new enrollment of children was due to crowd-out.²⁶ In an earlier study, Cutler and Gruber studied crowd-out caused by states' expansion of Medicaid to pregnant women and children from 1987 to 1992.²⁷ They found that 50 percent of the new Medicaid enrollment could be attributed to the crowding out of employer-based coverage. A recent paper by Lisa Dubay compares eleven different studies on crowd-out. Dubay explains that the results of the studies differ largely due to differences in the research question being asked, the type of data being analyzed, and the methods employed to establish what would have happened in the absence of the coverage expansion program.²⁸

While crowd-out is always a potential problem for publicly funded health care programs, researchers believe there is a greater threat of crowd-out when the population served is of a higher income range.²⁹ This is because people in the lower income ranges cannot afford to

Chapter Highlights:

- **Crowd-out is the phenomenon in which individuals or employers drop their private contributions toward insurance coverage when publicly funded coverage becomes available.**
- **To the extent that crowd-out occurs, public programs can cover fewer truly uninsured individuals.**
- **The prevention of crowd-out may or may not be an important policy objective for states. However, states using Title XXI funds to buy into employer-based coverage are required to implement a number of crowd-out prevention measures. (Such measures are not required under Medicaid programs.)**
- **This chapter presents data on the extent to which crowd-out has been associated with previous expansions of the Medicaid program. The chapter also includes an overview of measures states may take to prevent and monitor crowd-out.**

Program Design Question:

Will the program include provisions to limit and/or prevent “crowd-out” of private coverage? How will these be operationalized?

Requirements under Title XXI*:

- Enrollees must have been without employer-based coverage for a minimum of 6 months.
- Employers must contribute at least 60% of the cost of family coverage. (HCFA may also consider lower minimum employer contribution levels if other crowd-out provisions are in place.)
- States must monitor changes in employer contribution levels over time.

* Restrictions apply in all cases in which Title XXI funds are used, whether the Title XXI program is a Medicaid look-alike or a separate Children’s Health Insurance program.

make contributions to private coverage in the first place. Therefore, there are no contributions to be crowded out. However, private coverage buy-in programs target employed individuals who are, as a result of such employment, likely to have incomes well above the poverty level and to be making contributions to coverage.

B. What Can Private Coverage Buy-In Programs Do To Limit Crowd-Out?

State officials designing private coverage buy-in programs may consider a number of options for limiting crowd-out of both employer and employee contributions.³⁰ (Recall that if states intend to use Title XXI funds, federal law requires certain crowd-out prevention measures.) Policies and rules for preventing crowd-out are often collectively referred to as “firewalls.” Without the presence of firewalls, public programs may not be entirely effective in reducing the number of uninsured (if reducing the number of uninsured is the policy objective). However, firewalls that are too restrictive will simply leave uninsured people without access to care, undermining the goal of covering the uninsured. Commonly-used firewalls include the following:

- “Look-Back” Periods. As discussed previously, for states to use Title XXI funds to buy into private coverage, they must impose a 6-month look-back period. This means that a child is eligible for the subsidy toward employer-based coverage only if he or she has been without employer-based coverage for the past six months. Look-back periods are intended to remove individuals’ (or parents’) incentive to drop their existing contributions toward coverage to take advantage of a public subsidy. There is some evidence to suggest that look-back periods do in fact limit crowd-out (see *State Examples – Minnesota*, page 22). However, they also raise concerns about program equity. Consider the following example:

Employer A offers employees a health insurance plan and contributes 100 percent of the cost of employee coverage or 60 percent of the cost of family coverage. Joe Smith works for Employer A and makes minimum wage. Even with the 60 percent contribution his employer makes to family coverage, his other expenses are such that he decides he cannot afford the additional 40 percent of the premium. As a result, he only takes coverage for himself, leaving his child uninsured. Bob Jones also works for Employer A and makes minimum wage. However, Bob makes the decision to cut back on other expenses in order to pay the required 40 percent of the premium so that his child can be insured.

With a 6-month look-back policy, Bob Jones, who has ostensibly “done the right thing” in covering his child, cannot receive a subsidy toward the child’s coverage. In contrast, Joe Smith, who has not provided insurance for his child in the past, can obtain the subsidy immediately. The two men make the same wage and work for the same employer, but they do not have the same access to the public subsidy.

Note that while a six-month look-back period is required under a Title XXI buy-in program, no look-back is required under a Medicaid buy-in. State officials should keep this in mind in considering whether to use Title XXI, Medicaid, or state-only funds for the buy-in program.

Look-back periods, by definition, create the inequity described above. They also raise questions about states’ goals in designing a buy-in program. If the foremost goal is to make public dollars go as far as possible, a look-back period makes sense as a means of controlling crowd-out. If, however, the goal is to ensure continuous coverage for as many low-income people as possible, a look-back period may not be as desirable.

- Minimum Employer/Employee Contribution Requirements. A second means of limiting crowd-out is to require a minimum employer (and/or employee) contribution toward

coverage. Recall that under Title XXI, for a state to provide a subsidy for employer-based coverage, the employer must contribute at least 60 percent of the cost of family coverage (although HCFA is willing to consider a lower minimum contribution level if states can make a case for this). There are no such requirements under Medicaid. Officials designing a buy-in program should examine data in their own state to determine what level of minimum employer contribution is reasonable. For example, in poorer states, the average employer contribution toward coverage may be closer to 50 percent. Therefore, a rule that requires a 60 percent contribution may exclude many needy employees or cause states to forego available contributions.

- **Monitoring Changes in Employer Contributions.** While minimum employer contribution requirements do ensure employer financial participation in providing insurance, they do not in and of themselves guarantee that crowd-out will not occur. An employer previously contributing 70 percent toward dependent coverage could drop the contribution amount to 60 percent, and his employees would qualify for assistance under Title XXI. In this case, a limited amount of substitution of public for private dollars will have occurred. An example is useful:

An employer with a number of low-income workers offers employer-based coverage that costs \$150 per month for single-employee coverage and \$400 for family coverage (two adults and any number of children). The employer covers 100 percent of the cost of single coverage. He would also like to be able to provide insurance for his employees' children, but he can only pay \$280 (70 percent) toward family coverage. Joe Smith, one of the low-income employees, cannot afford the additional \$120 per month to purchase the family coverage for himself, his wife, and his two children.

Joe Smith and his employer learn that Joe's children are eligible for the Title XXI buy-in program. The employer realizes that he can "kill two birds with one stone:" he can lower his employer contribution toward coverage (which is good for his profit margin), and he can ensure that Joe's children receive coverage. The employer drops his family coverage contribution to 60 percent, or \$240 (saving \$40 per month per employee). Joe receives a Title XXI subsidy of, for example, \$60 per child (or \$120). Joe then only has to pay the remaining \$40 out of his own pocket. This is a "win-win" situation. The employer saves money and Joe can afford to cover his children. (Table 2 illustrates this example.)

Arguably, an employer making a decision to drop his contribution in this manner is making a rational decision in response to the incentives before him, particularly if he has many employees who qualify for the subsidy. State officials must ask themselves whether they wish to prevent this type of behavior, or whether this limited amount of crowd out is acceptable if it will mean additional children and/or families receive coverage. If states do wish to prevent this behavior, they

Table 2: Example of a Change in Employer Contribution in Response to the Availability of a Subsidy

	70% CONTRIBUTION SCENARIO <i>Pre Buy-In Program</i>	60% CONTRIBUTION SCENARIO <i>With Buy-In Program</i>
Employer Contribution	\$280 (70%)	\$240 (60%)
Employee Contribution	\$120 (30%)	\$40 (10%)
State Subsidy (for Two Children)	\$0	\$120 (30%)
Total Premium for Family Coverage	\$400 (100%)	\$400 (100%)

will need to monitor employer contribution policies before and after subsidies are provided. (Recall that if Title XXI funds are used, such monitoring is required.)

State Examples:

LOOK-BACK PERIODS AND OTHER FIREWALLS ASSOCIATED WITH PRIVATE COVERAGE BUY-IN PROGRAMS

Minnesota.³¹ Experts often point to the MinnesotaCare program as an example of a strict look-back period preventing crowd-out of private insurance. Under the MinnesotaCare program, part of a Section 1115 Medicaid expansion, health insurance is provided to families with incomes below 275 percent FPL. (Medicaid provides coverage to pregnant women and children under age two with incomes below 275 percent FPL, to children under five with incomes below 133 percent FPL, and to older children with incomes below poverty.) Applicants are ineligible for MinnesotaCare if they had any form of health coverage in the four months prior to application or if they had *access to employer-subsidized coverage* at any time during the eighteen months prior to application.³² This strict look-back policy does not apply to a person who loses employer-based coverage due to death, disability, or termination of employment. The policy does apply if an individual loses coverage due to his employer terminating the health insurance benefit.

A study by Kathleen Call and colleagues provides insight into whether these look-back periods have been successful in reducing crowd-out in MinnesotaCare.³³ The researchers conducted three cross-sectional telephone surveys. Two of the surveys, conducted in 1990 and 1995, included random samples of Minnesotans of all ages and were designed to track changes in rates of uninsurance in the state. The third survey, conducted in 1994, included a random sample of 800 individuals who were enrolled in MinnesotaCare in mid-1994. Call and colleagues found that only 7.1 percent of respondents reported substituting the MinnesotaCare program for existing private coverage. (Approximately 3 percent reported dropping employer-sponsored insurance, and 4 percent reported dropping individual coverage to enroll in MinnesotaCare.) While there may be a number of factors that have contributed to the relatively low level of crowd-out in the MinnesotaCare program, the look-back policy is likely an important factor.

Wisconsin. Under the BadgerCare program, the state will buy into employer-based insurance for eligible adults and children only if such individuals have been without employer-based coverage for the previous six months. In addition, families with *access to employer-based coverage* where the employer pays at least 80 percent of the cost of family coverage will not be eligible for BadgerCare at all, even if the family is not enrolled in the employer's plan.

State Examples:

LOOK-BACK PERIODS AND OTHER FIREWALLS ASSOCIATED WITH PRIVATE COVERAGE BUY-IN PROGRAMS

Massachusetts. Under the MassHealth Family Assistance Program, premium subsidies are available to families with incomes below 200 percent FPL, whether they are currently insured or not (i.e., there is no look-back period). However, families are eligible for different aspects of the program depending on their prior insurance status:

- *Uninsured families* (those with no other comparable coverage at the time of application) may receive a subsidy toward employer-based coverage, with the state receiving the Title XXI match rate, provided coverage meets the Title XXI benefits standards and cost-effectiveness test.³⁴ If the cost-effectiveness test is not met, the children may still be enrolled in the direct coverage program under Title XXI, although the parents may not receive benefits.
- *Insured families* (those who are currently enrolled in an employer-based or other comparable plan) may also receive a subsidy toward employer-based coverage, provided the employer contributes at least 50 percent of the cost of family coverage, and the benefits meet a basic, state-defined minimum. However, for these families, if the subsidy does not cover the entire cost of the employee's contribution toward family coverage, the family does not have the option of enrolling in the direct coverage program. Instead, the family may take the available subsidy and pay the remainder of the premium out-of-pocket. In this case, the subsidy is the amount the state would have paid to enroll only the children in the direct coverage program. The state receives the Medicaid match rate for families in this situation (under its Section 1115 waiver), as Title XXI rules prohibit states from drawing down the enhanced match for currently insured individuals.

In neither case is there a look-back period. The state will monitor whether the lack of a look-back period leads to employers and/or families dropping their contributions toward coverage. If it is determined that this type of crowding out is taking place, the State will implement a 3-month look-back period, or the state and HCFA will collaborate on an alternative corrective action. (Note that Massachusetts' plan does not include the 6-month look-back period suggested in HCFA's guidelines for Title XXI private coverage buy-in programs.³⁵ However, currently insured families may not receive assistance unless they remain in the employer-based plan with the employer contributing at least 50 percent of the cost of family coverage. State program officials argued successfully that because of this policy, there would be little incentive for families to drop private coverage.)

Oregon. Under the state-only Family Health Insurance Assistance Program (FHIAP), individuals are eligible for subsidies only if they have been without insurance for at least six months. Applicants are required to provide this information on the program application. The state proceeds with enrollment based on receipt of an employer-sponsored insurance verification form (when applicable) and the applicant's assertion that he or she has been uninsured for at least six months. During periodic audits, the state will attempt to verify this information for a random sample of enrollees by matching enrollees' social security numbers against the databases of insurance carriers participating in FHIAP. These carriers represent approximately 70 percent of Oregon's group health insurance market.

5. EMPLOYERS' ROLES, ENROLLEE CONFIDENTIALITY, AND ADMINISTRATIVE BURDENS

Policymakers will need to make a number of decisions that have implications for the role of employers in administering a buy-in program. Potential roles for employers include:

- Informing employees about the private coverage buy-in program by distributing pamphlets, providing phone numbers, etc.;
- Providing states with information about the types of coverage available to employees, the total cost of the coverage, and the employer contribution amount; and,
- Assisting states in the administration of subsidies by modifying employees' payroll deductions (for insurance premiums) and/or remitting subsidies to carriers.

These potential roles for employers are discussed in detail under Section II(B) of this Guide – *Program Operations*. However, state health officials should be aware of the general issues of employee confidentiality and administrative burden as they relate to employers' roles.

- **Confidentiality.** Although in many cases it may be administratively simpler for states to partner with employers in key aspects of a buy-in program, officials should consider the implications of designing a program that requires an employer to know when an employee is participating. Some potentially eligible individuals may be uncomfortable with sharing this type of information with their employers and may be reluctant to participate.
- **Employers' Administrative Burden.** States should also think carefully about the extent to which the program will place an administrative burden on employers. For example, if employers are expected to assist in providing detailed information about employees' benefits and in administering subsidies, some may not want their employees to learn about the program. Program officials should consider whether they wish to design a program in which the employee may not participate unless the employer is willing to perform certain functions. If the program does rely heavily on voluntary employer cooperation, states may want to incorporate employer incentives into the program. For example, under its MassHealth Family Assistance Program, the state of Massachusetts has implemented an Insurance Partnership program for small employers. Under this program, small employers receive a subsidy for every employee who participates in the buy-in. Employers use this subsidy to offset their own costs of providing health insurance for their employees.

Chapter Highlights:

- There are a number of ways in which employers may assist states in marketing and/or administering a private coverage buy-in program.
- This chapter presents an overview of two issues states should consider in designing a program that depends on the cooperation of employers:
 - 1) employee confidentiality; and
 - 2) employers' administrative burden.

6. COST-EFFECTIVENESS AND FAMILY COVERAGE

States that wish to use Title XXI or Medicaid funding for a private coverage buy-in program must comply with federal rules regarding cost-effectiveness. The rules are essentially the same under Title XXI and Medicaid:

States may use public funds to buy into private coverage for program eligibles if the cost of doing so does not exceed the cost of enrolling the eligibles in the public program.

In the case of Title XXI, the eligibles that may be included in this calculation are children only. In the case of Medicaid, eligibles may also include adults. Note that the cost of buying into private coverage includes not only the premium for the plan, but also the cost associated with any benefit or cost-sharing wrap-arounds used to supplement the private plan.

State officials designing a private coverage buy-in program should be aware of several issues related to the cost-effectiveness of family coverage, a category of insurance sold in the private market. Normally, insurance carriers charge different premiums for different rating tiers. For example, common rating tiers include:

- Employee-only;
- Employee and spouse;
- Employee and one or more children; and,
- Family (including employee, spouse, and one or more children).

Note that in this example, there is no category for child-only coverage. As a result, states that wish to buy into private coverage for children must (in almost all cases) buy into a plan that covers at least one adult and a number of children, often called family coverage. The phenomenon of family coverage raises two important issues for a private coverage buy-in program: a) subsidization of non-eligible family members; and b) determination of cost-effectiveness for smaller families.

A. Subsidization of Non-Eligible Family Members

In some instances, the rating tier structure described above may result in a state subsidizing coverage for an adult who is not eligible for the program. For example:

- Employer A offers health insurance to his employees, paying 100 percent of the cost of employee-only coverage, and 60 percent of the cost of family coverage. The family coverage tier includes the employee, the spouse, and one or more children. The total cost for family coverage is \$400, so Employer A contributes \$240.
- Jane Doe is an employee of Employer A. She has a husband and two children. She cannot afford the additional \$160 to cover her spouse and children, so she takes coverage only for herself.
- Jane's children are eligible for the Title XXI program. Under the public program, the state can pay up to \$80 per child. Therefore, to meet the cost-effectiveness test, the state may pay up to \$160 to cover Jane's two children under her employer-based plan.
- Together, the \$160 state subsidy and the \$240 employer contribution cover the total cost of the family coverage (\$400 per month). As a result, not only are Jane's children able to enroll in the employer-based plan, but her spouse may enroll, too (because the family tier includes the employee, spouse, and one or more children).

Chapter Highlights:

- States that wish to use federal funds to buy into private coverage may do so only when it is cost-effective. This chapter explains what is meant by cost-effectiveness under Medicaid and Title XXI rules.
- Because private insurance is often sold as family coverage (including both children and adults), it may sometimes be possible for states to subsidize private coverage for individuals who are not otherwise eligible for public programs. The chapter provides examples of such situations.
- In addition, because family coverage is often priced based on an assumption that families include an average of just less than two children, it may be difficult for states to meet cost-effectiveness tests when buying into family coverage for single-child families. This chapter provides examples of such situations and presents alternate means of meeting the cost-effectiveness test for both small and large families.

Program Design Question:

How will the State determine whether it is cost-effective to buy into private coverage for a given person or family?

- States may buy into private coverage for an individual if the cost of doing so does not exceed the cost of enrolling the individual in the public program.
- States may also buy into private coverage on behalf of non-eligible family members if the cost of doing so does not exceed the cost of enrolling the eligible member in the public program.
- Because private insurance is often sold as “family coverage” (including both children and adults) it may be possible for states to off-set private coverage costs for family members who are not otherwise eligible for the public program.
- In the case of programs funded with Title XXI dollars, a “family coverage variance” may be required.

In this way, the public program may subsidize an individual (the spouse) who is not technically eligible for the program. This type of subsidization is permitted under both Title XXI and Medicaid. However, depending on the public program’s eligibility rules, such subsidization may require a family coverage variance under Title XXI. HCFA is still developing guidelines related to the family coverage variance. State officials designing buy-in programs with Title XXI or Medicaid dollars should discuss this point with HCFA representatives to determine whether the variance is required.³⁶

B. Determining Cost-Effectiveness for Smaller Families

Common insurance industry rating tier structures, such as the one described above, may cause problems for states in establishing cost-effectiveness for smaller families. Often, there is no tier for employee plus one child. Instead, insurance is frequently sold under structures that include tiers for employee plus *child or children* or employee, spouse, and *child or children*. The tiers that include child or children assume, in most cases, an average of close to two children. Premiums for these tiers are more expensive than they would be if they were based on only one child. Therefore, it will rarely be cost-effective for a state to buy into employer-based coverage for a single-child. For example, returning to Jane Doe and Employer A (above):

- Assume this time that Jane Doe has only one child. Therefore, the state may only pay up to \$80 to enroll Jane’s family in the employer-based plan.
- With the employer contributing \$240, and the state contributing \$80, it is not possible to cover the entire cost of the employer-based plan, which is \$400 for family coverage. (The price is high for a family with only one child because the insurance carrier assumes an average of close to two children per family.)
- The cost-effectiveness test cannot be met, and Jane’s child will be enrolled in the public program.

As a result of this rating structure, it will almost never be cost-effective for a state to buy into family coverage for a single-child family (unless the employer is contributing an unusually large amount toward family coverage.) On the other hand, states can save significant amounts of money by enrolling large families in employer-based coverage under this type of rating structure. Returning to Jane again:

- Now assume that Jane has four children. It would cost the State \$80 per child, or \$320, to enroll the children in the public program.
- However, it will cost the state only \$160 to enroll all four children (and the spouse) in the employer-based plan because the total premium for the family is only \$400, and Employer A contributes \$240.

Under this type of rating structure, it will almost always be cost-effective for a state to buy into employer-based coverage for large families. Some states are concerned about developing a buy-in program that, due to insurance rating practices, is available only to large families and not to small families. Insurance carriers may also be wary of such a program. When carriers base their family premiums on an assumption of two children, they lose money by enrolling many larger families. State officials may, therefore, wish to consider alternate means of calculating cost-effectiveness.

One possibility is for states to determine the cost-effectiveness of a buy-in program on an average family size, rather than *specific* family size, basis. Rather than comparing the employer-based plan subsidy amount to what the state would pay under the public program for a specific family, states could compare the subsidy amount to what the state would pay under the public

program for the average-sized family. For example, assume the average number of children in the employee plus child or children tier (in the private insurance market) is two. Assume that the state's average public program costs are \$80 per child (under a Title XXI program). Under this scenario, the cost-effectiveness test would be met as long as children's subsidies toward employer-based coverage were no more than \$160, or the amount required for the *average-sized* family in the employee plus child or children tier. Although this method of calculating cost-effectiveness would allow a state to pay more than the \$80 in some cases for a single-child family, it would also prevent the state from paying more than \$160 for a family with three, four, or more children. On average, cost-effectiveness would be achieved.

It is unclear at this time whether HCFA will permit this type of approach. States designing private coverage buy-in programs should consult the federal agency.

B. Program Operations

After considering the general program design issues, states will need to focus on a number of operational issues. The following operational issues are discussed in this section:

- Identifying potential program eligibles;
- Gathering information about participants' private coverage;
- Supplementing benefits and cost-sharing provisions;
- Administering subsidies; and,
- Partnering with an existing consumer-choice health purchasing group.

1. IDENTIFYING POTENTIAL PROGRAM ELIGIBLES

The identification of individuals who are potentially eligible for a private coverage buy-in program can be a challenge for states. To be eligible, individuals must meet two criteria (at a minimum):

- They must be eligible for the public program (whether it is Title XXI, Medicaid, or a state-only program); and,
- They must have access to employer-based or other private coverage.

In identifying such individuals, states have two options. They can start with public program eligibles and attempt to find out if private coverage is available to them. Alternately, they can start with low-income workers and attempt to find out if they qualify for the public program. A combination of the two approaches is probably best.

A. Public Programs as a Source of Potential Eligibles

In many states, applications for public programs include questions about applicants' other available coverage. State officials designing a buy-in program should determine whether such relevant questions are already included in Medicaid or other public program applications. If not, they may need to add questions, keeping in mind that public program applications should be kept as short and simple as possible. At a minimum, an application should ask whether the applicant is employed and whether the employer offers health insurance as a benefit for the applicant and/or his dependents. The answers to these two questions will help state officials determine whether they need to follow up with the applicant to learn more about the employer-based coverage. Officials should recognize, however, that some applicants may be hesitant to be truthful about their access to employer-based coverage, for fear that having such access might jeopardize their eligibility for the public program.

State Example: Massachusetts

USING THE PUBLIC PROGRAM APPLICATION AS A SCREENING TOOL

The MassHealth program application asks whether the applicant has (or has access to) employer-based coverage. If the applicant answers in the affirmative, an "insurance investigation period" is triggered, with the state contacting the employer to gather additional information. However, state officials do not rely entirely on applicants' answers to questions about access to coverage. The state initiates the insurance investigation period for all applicants who indicate that they are employed, whether or not they indicate that other coverage is available.

B. Employers as a Source of Potential Eligibles

An additional means of identifying potential buy-in program participants is to target low-income workers. States may develop materials that can be distributed to employers through business associations, chambers of commerce, or directly. Many employers will be appreciative of the opportunity to assist their employees in this way. On the other hand, some employers may not want to provide information about a buy-in program, because greater participation in the employer's plan will mean the employer must make contributions for more people. In addition, some employers may not wish to be involved in marketing a service or benefit that is only available to some, but not all, of their workers.

Chapter Highlights:

- This chapter describes several methods states may use to identify individuals who may be eligible for a private coverage buy-in program.
- Methods include: using the public program application as a tool to screen for access to private coverage; marketing to (and through) employers; partnering with insurance agents; and, performing automated data matches against insurance company eligibility files or state employment databases.
- State examples are provided.

Operational Question:

How will the State identify potential program eligibles?

Options:

- Use the public program application as a tool to screen for access to private coverage.
- Market to (and through) employers.
- Partner with insurance agents.
- Perform data matches against insurance company eligibility files or state employment databases.
- A combination of approaches may allow states to reach the greatest number of individuals who meet program eligibility requirements and have access to private insurance.

Note: Both private coverage buy-ins and public Title XXI programs are required to screen applicants for Medicaid eligibility.

C. Insurance Agents as a Source of Potential Eligibles

States may also wish to provide information or training to insurance agents. For many small businesses, the insurance agent acts as the human resource department and is well-positioned to provide an employer and his employees with information about the buy-in program. Because agents are often paid commissions (by insurance carriers) based on the number of people that enroll in a plan, they have a financial incentive to enroll as many people from the employer group as possible. It is, therefore, in the agents' best interest to let employees know about the availability of a subsidy, thereby increasing the chances that more employees will be able to join the plan.

State Example: Oregon

PARTNERING WITH INSURANCE AGENTS

The Oregon Family Health Insurance Assistance Program (FHIAP) uses agents to market the program and to help participants enroll in individual coverage (when group coverage is not available). The FHIAP provides training for the agents and matches them with applicants who may need their assistance. All agents in the state can assist applicants with program enrollment, but only those who have undergone the FHIAP training can receive referrals from the state. As part of the training, agents learn about other programs for which individuals might be eligible, such as Medicaid, the Medicaid look-alike public Title XXI program, and the state's high-risk pool. Agents are required to include information about these other public programs when they provide assistance with FHIAP enrollment. When a person purchases either group or individual coverage using a FHIAP subsidy, the agent receives a commission from the carrier.

Oregon officials expect to have from 230 to 260 agents throughout the state working with the program. Early FHIAP enrollment data show that the majority of applicants are learning about the program from a health insurance agent or from a Medicaid or welfare case-worker.

D. Automated Data Matches

State officials may also use automated data matches to identify potential program eligibles. For example, a state could compare public program eligibility files to state income tax data to determine whether public program participants are employed (and may, therefore, have access to employer-based insurance).

State Examples:

AUTOMATED DATA MATCHES

Texas and Iowa. Texas' Health Insurance Premium Payment (HIPP) program uses a system that matches state employment and Medicaid eligibility data. However, Texas program officials note that employment data are not always current, limiting the effectiveness of this approach. Iowa uses a similar computerized matching system to identify potential HIPP program eligibles, but officials in that state report that this method has not proven particularly useful.³⁷

Wisconsin. In Wisconsin, all major insurance carriers are required to submit to the Badger-Care program a semi-annual report listing all currently enrolled individuals. The majority of carriers submit these reports monthly. State officials will use this information in a retrospective process as one means of identifying adults and children enrolled in private coverage. Wisconsin has not yet implemented this approach, so it is too early to determine whether it will be successful and/or useful.

Massachusetts. Under the MassHealth Family Assistance Program, officials use an automated data match as one of several means of determining whether program applicants have access to employer-based coverage. The MassHealth program receives monthly eligibility files from several of the state's largest commercial carriers. Using these data, officials can determine whether program applicants are currently covered by an employer-based plan. They cannot, however, determine whether applicants have access to coverage (i.e., the employer offers it) but are not enrolled. In addition, carriers' eligibility systems track social security numbers only for primary subscribers, not for dependents. As a result, officials cannot use these data to perform a match for children. Officials are currently working on improvements to the data matching system to eliminate some of these problems.

2. GATHERING INFORMATION ABOUT PARTICIPANTS' PRIVATE COVERAGE

To administer a private coverage buy-in program, states need certain information regarding the coverage available to participants. Specifically, states need information regarding:

- Covered benefits;
- Cost-sharing requirements;
- Total premiums; and,
- Employer and employee contributions toward premiums (if applicable).

States need this information to determine whether available private coverage meets the program's benefits and cost-sharing standards, if any. They will also use this information to determine whether the purchase of private coverage meets the cost-effectiveness test required by Title XXI and Medicaid law (if applicable). There are essentially three options for states to gather information regarding available coverage: they can gather such information from the program participant, the participant's employer, or the insurance carrier or third party administrator.

A. Gathering Information from Participants

Perhaps the simplest means of gathering information about available benefits is to request such information from participants. This option does not raise any concerns about breaching participant confidentiality, as it does not require either an employer or an insurance carrier to be notified. However, some states have found that participants do not have all of the relevant information about their benefit plans and that their response to requests for this kind of information is minimal. In addition, while many employees may know their own contribution to employer-based coverage, they may not know the total premium and, therefore, the employer contribution.

Under the federal Employee Retirement Income Security Act (ERISA), employees have a right to obtain information from their employers regarding their health benefit plans. This provision of ERISA applies to employees of both self-insured and fully insured employers.³⁸ Under ERISA, enrollees in an employer-sponsored plan must be provided with a Summary Plan Description (SPD), either by the employer or the carrier, within 90 days of receiving coverage. Plans must also make the latest version of the SPD available to plan participants and eligibles upon request and at a reasonable cost. Often, SPDs include only a benefits summary, rather than a detailed schedule of benefits. If this is the case, however, the SPD must note that the detailed schedule of benefits is available upon request and without charge to participants covered by the plan.

B. Gathering Information from Employers

Employers are somewhat more likely than employees to have accurate and complete information about available benefits. For states to obtain information from employers, however, they must be willing to breach employees' confidentiality regarding program participation. In addition, the U.S. General Accounting Office reports that under the Medicaid Health Insurance Premium Payment (HIPP) programs, some states (but not all) have found that employers are not willing to cooperate.³⁹ Officials from Iowa's HIPP program noted that it is often more difficult to obtain information from self-insured employers than from fully insured employers. The failure of employers to cooperate is problematic because while employees have a legal right to obtain benefits information from their employers (see above), the state has no such legal standing to demand information.⁴⁰

Chapter Highlights:

- Buy-in programs will likely need to gather information about applicants' available private coverage. Such information may include: covered benefits, cost-sharing requirements, total premiums, and employer/employee contributions toward coverage.
- This chapter describes how states might gather the required information from participants, employers, or insurance carriers. For each method, the chapter explores issues related to employee confidentiality, administrative simplicity, and the likelihood of obtaining the required information.
- State examples are provided.

Operational Question:

How will the State gather information about participants' private coverage?

Options include soliciting information from:

- Participants
- Participants' employers
- Insurance carriers

Issues to consider:

- Under Title XXI and Medicaid, benefits and cost-sharing must meet a minimum level. As a result, it is important for states to obtain accurate and detailed information about participants' coverage.
- Employers and insurance carriers may be more likely than employees to have accurate information.
- For states to obtain information from employers or insurance carriers, they must breach participants' confidentiality regarding program participation.
- The only option that does not require a breach of confidentiality is to request information from participants' themselves. However, states may be unable to obtain sufficiently detailed information from participants.

C. Gathering Information from Insurance Carriers or Third-Party Administrators

Insurance carriers or third-party administrators (TPAs) can also be a source of accurate and detailed information about a participant's coverage. Employees who do not want their employers to be aware of their participation in the public program may be less concerned about an insurance carrier having such knowledge. In addition, carriers may be an important source of information when a participant has an individual (rather than employer-based) plan but does not know very much about it. To identify the appropriate carrier or TPA, states will need to obtain basic information from the participant/employee, such as the participants' social security number (which is probably already required in the program application) and the carriers' name. Participants who are already enrolled in a private plan can simply present state officials with a copy of the health plan membership card. If they are not currently enrolled, however, participants may have to obtain additional information from their employers, raising the issues of confidentiality and lack of participant follow-through.

Unlike employers, who may or may not believe it is to their advantage to assist employees in enrolling in a buy-in program, insurance carriers are likely to be motivated to help in this way. For purposes of increasing their business and spreading risk, insurance carriers prefer to cover more — rather than fewer — people. They may, therefore, have an incentive to provide states with information that may result in additional employees and their dependents joining an employer's plan.

State Examples:

GATHERING INFORMATION ABOUT AVAILABLE COVERAGE

Wisconsin. Under the BadgerCare program, which uses a combination of Medicaid and Title XXI funds, county eligibility workers will ask applicants if their employers offer health insurance. Whether or not the applicant indicates that employer-based coverage may be available, the BadgerCare administrator will send a form to the employer, asking for information about contribution levels, benefits, and cost-sharing requirements. (Employers will not be contacted without the permission of the employee/applicant.) State officials are currently developing this form in cooperation with an advisory group of employers and insurance representatives. After the form is mailed to the employer, there will be a series of follow-up calls at scheduled intervals. If no response is received from the employer within approximately eight weeks, the applicant will be enrolled in a managed care plan under the public program (assuming he or she is otherwise eligible). While the State is waiting for a response from the employer, the individual will be covered under the public program on a fee-for-service basis.

Texas. Under Texas' Health Insurance Premium Payment (HIPP) program, Medicaid eligibility workers identify potential HIPP participants as part of the Medicaid application process. If an applicant indicates that he or she is employed and may have access to employer-based coverage, the eligibility worker forwards the applicant's name to the HIPP program administrators. The HIPP program, in turn, contacts the employer directly to gather information on available coverage.

State Examples:

GATHERING INFORMATION ABOUT AVAILABLE COVERAGE

Oregon. Under the state-only Family Health Insurance Assistance Program (FHIAP), applicants are required to fill out an Employer Verification Form. Participants may fill out the form themselves, or they may authorize the employer to fill it out on their behalf. Participants receive the form after they are accepted into the program, whether or not they have indicated that employer coverage is available. (If employer coverage is not available, FHIAP participants have the option of purchasing an individual plan from one of the program's certified carriers.) Oregon is able to obtain coverage information *after* eligibility determination because eligibility does not depend on the type of coverage available. Recall that, unlike programs that use federal funds, Oregon's state-only program does not include any requirements regarding benefits (under group coverage) or employer contribution levels. The Employer Verification Form asks for information on the insurance carrier, the type of plan (HMO, PPO, etc.), the total premium for the plan, and the employer contribution toward both employee and dependent coverage. Oregon officials report that there has been some difficulty in the Employer Verification Form completion process, and they have revised the form by making certain questions more specific. Officials also report that some FHIAP participants have been concerned about informing their employers of their participation in the program. Although program officials value the principle of participant confidentiality, they have not yet developed an effective, alternate means of obtaining the required information.

Oregon is currently developing a Title XXI State Plan amendment that will allow the FHIAP to access Title XXI funds for eligible children. As discussed previously, to obtain federal funds states must ensure that covered benefits and cost-sharing provisions meet federal requirements. As a result, Oregon officials will need to revise the Employer Verification Form to ask additional, detailed questions about covered benefits and cost-sharing requirements.

Massachusetts. Under the MassHealth Family Assistance Program, officials determine whether the applicant may have access to employer-based insurance based on information provided by the enrollee or obtained through an automated data match. If so, the state begins its "Insurance Investigation Period." During this period, state officials contact the employer by phone to request information regarding benefits, employer contributions, and total premium. The phone call is followed by a letter sent to the employer, explaining the Family Assistance Program. (This letter is included as Appendix E). State officials report that employer response to requests for information has been good.⁴¹ Most employers provide the required information within a number of weeks. During the Insurance Investigation Period, while the state is waiting for information from the employer, children applying for the program are enrolled in temporary, fee-for-service coverage for 60 days. (Adults do not receive such temporary coverage while waiting.)

3. SUPPLEMENTING BENEFITS AND COST-SHARING PROVISIONS⁴²

If states wish to use federal funds for a buy-in program, they must ensure that participants receive coverage that meets certain benefits and cost-sharing requirements. Officials may also develop such requirements for a state-only program. This section addresses three issues related to benefits and cost-sharing requirements:

- What are the federal benefits and cost-sharing requirements for Title XXI and Medicaid programs?
- How can states determine whether program applicants' available coverage meets such requirements?
- What can states do to supplement applicants' private coverage if it does not meet the requirements?

A. Medicaid Benefits and Cost-Sharing Requirements

For states to use Medicaid funds to buy into employer-based coverage, they must ensure that the resulting coverage meets all Medicaid benefits and cost-sharing requirements. The term resulting coverage is used here to refer to the employer-based coverage, plus any additional coverage the state provides as a wrap-around.

- **Benefits.** A Medicaid private coverage buy-in program must provide the same services as are provided under a state's regular Medicaid program. These services may include those required by federal law, in addition to any "optional" benefits a state has elected to cover under its Title XIX State Plan. The federally required services are: inpatient and outpatient hospital, lab and x-ray, physician services in all settings, nursing facilities, home health care, Early and Periodic Screening, Detection, and Treatment (EPSDT) services, pregnancy-related services, nurse-midwife and nurse practitioner services (if state law authorizes such practices), family planning, and rural health services.⁴³
- **Premiums and Cost Sharing.** Under Medicaid, states may not impose premiums on enrollees classified as categorically needy. States may, however, impose premiums on individuals, including children, who are medically needy. There may be no cost sharing (on services) for children under age 18, regardless of whether they are categorically needy or medically needy. There may be only nominal cost sharing for non-pregnant adults. Nominality is determined in relation to the level of cash assistance provided in a state and other criteria set forth in regulation by HCFA. Federal regulations define reasonable premium requirements and cost-sharing ranges that are considered nominal.⁴⁴

B. Title XXI Benefit and Cost-Sharing Requirements

For states to use Title XXI funds to buy into employer-based coverage, there are three parameters under which such coverage must meet federal requirements:

1. Covered Services. Employer-based coverage must include the Title XXI required services. At a minimum, qualified plans must cover inpatient and outpatient hospital care, physician care, laboratory and x-ray services, well-baby and well-child care, and age-appropriate immunizations. In addition, if the state's benchmark plan covers mental health, prescription drugs, vision services, and/or hearing services, the state's Title XXI coverage must also provide for these services.⁴⁵ If the employer plan does not meet the Title XXI covered services requirements, the state must determine what type of benefit rider would be necessary to bring the coverage into compliance.

Chapter Highlights:

- States using federal funds for a buy-in program must ensure that participants receive coverage that meets certain benefits and cost-sharing requirements. This chapter reviews the benefits and cost-sharing requirements under Title XXI and Medicaid.
- The chapter also describes several systems states may use to assess the benefits and cost-sharing requirements of program participants' private coverage. Options include: a check-off form, partnering with insurance carriers, taking advantage of small group insurance reform, partnering with employers, and partnering with purchasing groups (such as chambers of commerce, etc.).
- Options for states to administer benefits and/or cost-sharing wrap-arounds (when participants' private coverage does not meet requirements) are described. Illustrations of these options are included in Appendix E
- State examples are provided.

Operational Question:

Will the program include minimum benefits and/or cost-sharing requirements?

- If so, how will the State determine whether a participants' private plan meets the requirements?
- Will the State supplement private plans that do not meet the requirements?
- How will a supplement be administered?

Notes:

- If private coverage does not meet these requirements, the State may provide "wrap-around" coverage or enroll the individual directly in the public program.
- In administering "wrap-arounds" under Title XXI, states may not require participants to incur any out-of-pocket expenses other than those permitted by law, even if they are to be reimbursed.

2. Actuarial equivalence. In addition to covering the Title XXI required services, employer-based plans must be at least actuarially equivalent to the state's benchmark plan for Title XXI. Actuarial equivalence can be determined on benefit-by-benefit or overall basis.⁴⁶ If the benefit plan does not meet the actuarial equivalency tests, states must determine the value of the additional benefits that would need to be added to bring the plan into compliance with Title XXI.
3. Cost sharing. Title XXI includes the following requirements regarding cost sharing, whether coverage is provided under a public program or an employer-based coverage buy-in program:
 - There may be no cost-sharing for well-baby, well-child, and immunization visits;
 - Families with incomes below 150 percent FPL may pay no more than the Medicaid-level of copays, which includes \$3 office visits;
 - Families with incomes over 150 percent FPL may pay no more than 5 percent of their total income for children's cost sharing in a given year (including both premium contributions and cost-sharing at the point of service).

C. Assessing Applicants' Available Coverage

To comply with benefit and cost-sharing requirements, state officials designing a buy-in program must develop a mechanism for assessing applicants' coverage. It is important that this mechanism be as streamlined as possible; otherwise, the administrative demands on the buy-in program will quickly become unmanageable. Clearly, a complete, actuarial analysis of every applicant's available private coverage is administratively burdensome. However, there are other options that states may pursue:

- **Check-Off Form.** For Title XXI programs that elect to use the benefit-by-benefit method of determining actuarial equivalence to a benchmark, states can develop a check-off form that asks yes/no questions about covered services. Such a check-off form could also be used for programs that do not have actuarial equivalence requirements (Medicaid or state-only programs). This form could be filled out by the program participant or by his or her employer (see Section II(B)(2) of this Guide — *Gathering Information about Participants' Private Coverage*). The form would also have to include specific questions about the co-pays for various types of services (e.g., office visit, hospital stay, emergency room visit, etc.).
- **Partnering with Insurance Carriers.** Buy-in program officials could work with their state's Department of Insurance to identify several insurance carriers that serve a large portion of the group market. The state could work with such carriers to perform an assessment of a number of benefit plans they already sell in the private market. The state could "pre-certify" a number of plans as meeting program requirements. For example:

A state could determine that the \$10 copay HMO offered by Health Insurer XYZ includes the appropriate benefits and cost-sharing provisions. When an individual applies for the buy-in program, officials would determine whether he or she is covered by this plan from this carrier. If so, no further analysis would be necessary to ensure compliance with federal requirements. If not, states would need to decide whether they are willing to perform further analysis of the applicant's plan, or whether the applicant would simply be unable to participate in the buy-in.

In this case, officials would have to weigh administrative simplicity against the ideal of making the program accessible to as many people as possible. By choosing the largest (i.e., most popular) plans in the state to pre-certify, officials may hope to make the program accessible to a large number of people, recognizing that some individuals will still be excluded. This is the approach that state officials in Oregon hope to take under the Title XXI buy-in program. In that state, several large HMOs cover 80 percent of the group market. The state plans to certify at least one basic benefit package offered by each of these large carriers.

- **Taking Advantage of Small Group Insurance Reform.** As described previously and in Appendix D, many states currently have some form of insurance reform in the small group market.⁴⁷ Often, such reforms include provisions that require all small group carriers to offer a number of standardized plans. Such standardized plans are more popular in some states than they are in others. Again, a state's department of insurance could help buy-in officials determine the extent to which small employers purchase the standardized plans. If they are popular and meet the relevant benefits and cost-sharing requirements of the buy-in program, states could pre-certify the standardized plans. The only difference between this approach and the approach described above is that the standardized plans are offered by all insurance carriers in the market, rather than by a single carrier (thus broadening the group of carriers that could participate in the buy-in).
- **Partnering with Employers.** States may also consider pre-certifying the benefit plans offered by a number of large employers in the state. Under this scenario, buy-in program applicants who worked for employers with pre-certified plans would be able to participate. Similar to the above two options, states will need to determine whether applicants not enrolled in the pre-certified plans (because they don't work for the employer) can participate in the buy-in program. This approach might be more desirable on a pilot-program basis with a few large employers.
- **Partnering with a Purchasing Group.** In many states, there exist entities that purchase insurance coverage on behalf of employers and individuals. Such entities include consumer-choice health purchasing groups (CHPGs), business associations, chambers of commerce, etc.⁴⁸ In most cases, these groups offer a variety of standardized plans to their member employers. By pre-certifying qualified plans offered by purchasing groups, program officials might be able to reach a broader cross-section of employers than they would by pre-certifying plans offered by a number of specific employers.

D. Options for Supplementing Private Plans That Do Not Meet Program Requirements

In cases where an applicant's private coverage does not meet program requirements regarding covered services and/or cost-sharing, states have two choices (if they intend to use federal funding): they can either disqualify the applicant from the buy-in program, or they can develop and administer a wrap-around plan to supplement the applicant's coverage. There are several options states may consider for supplementing private coverage. Regardless of the chosen option, however, the administrative burden of developing and administering wrap-arounds will be substantially lessened if states use one of the above methods of pre-certifying a limited number of benefit plans. In other words, rather than developing wrap-arounds to supplement any plan an applicant may have (on a case-by-case basis), states can develop wrap-arounds based on a limited number of pre-certified plans offered by large carriers, large employers, purchasing groups, etc.

While development of wrap-arounds or riders to cover previously non-covered services is straight-forward, the development of wrap-arounds to address cost-sharing requirements is

somewhat more complicated. If the private coverage does not include the required cost-sharing provisions, states must make arrangements to cover cost-sharing expenses that exceed these limits. Perhaps the simplest method for covering these expenses would be for families to keep cost-sharing receipts and submit them to the state for reimbursement. However, in reviewing Colorado's Title XXI State Plan, HCFA indicated that it is not permissible for families to incur any expenses beyond the specified cost-sharing limits, even if the state reimburses families for such expenses. Presumably, the same rule applies for a Medicaid-funded buy-in program. Given this restriction imposed by HCFA, many states are looking for ways of administering a cost-sharing wrap-around that do not involve reimbursing program participants. The following is a description of several such options:

1. Vouchers, or Provider-State Billing. States could pay providers directly for any co-pay amounts above the permitted levels. For example, states could issue vouchers that families would submit to providers in lieu of copays when required. If a Title XXI child were enrolled in a \$10 co-pay plan, but the family's income was below 150 percent FPL, an office-visit voucher would be worth \$7, and the family would pay the remaining \$3. This approach would work best when the private coverage included flat-dollar-amount co-pays (e.g., \$10 per office visit), rather than variable coinsurance amounts (e.g., 20 percent of charges, etc.).

Alternately, a state could forego the vouchers and require providers to bill the state directly. This is the approach normally used under states' Medicaid Health Insurance Premium Payment programs. For this approach to work, families would need to present the provider with an identification card that indicated participation in the buy-in program. Upon seeing this card, the provider would know to bill the state for the cost-sharing. This approach would likely require families to carry two health plan cards: one for the employer-based plan, and one for the public program, indicating that cost sharing should be billed to the state.

The drawback to both these approaches is that providers would be required to submit vouchers or bills to the state for reimbursement. States, in turn, would need systems in place to pay providers. Most states currently have such systems in place under their existing Medicaid fee-for-service programs. Medicaid programs normally assign providers a Medicaid identification number and pay them through the Medicaid Management Information System (MMIS). However, under a buy-in program, participants will receive services from a wide variety of providers who contract with employer-based insurance plans. It is likely that a large number of such providers will not have Medicaid identification numbers because they have never served the Medicaid program directly. In such cases, states may need to assign providers a Medicaid identification number solely for purposes of administering the buy-in program. Alternately, states could pay providers through a system other than the MMIS.

To date, HCFA has approved this type of approach for Title XXI and/or Medicaid buy-in programs in Massachusetts and Wisconsin (see state examples below).

2. Cash. States could determine, based on actuarial analysis, the value of the differential between the employer-based plan's cost-sharing requirements and the buy-in program's requirements. A state could pre-pay the family for the expected co-pay amount on a quarterly or some other basis. Families would then have sufficient cash in hand at the time of service to cover the full co-pay. State officials may be concerned that families would spend the cash on items other than co-pays (such as food or utilities). Although some families may do this, it is likely that many families, after having gone to the trouble to enroll in the program and receive the subsidy, would be motivated to use the money for medical care. On the other hand, in the few cases where the family does spend the money on other items, they may forego accessing medical care because they don't have money left for copays. In

addition, there are concerns related to pre-paying co-pays based on expected average utilization. For families that use less than the average amount of care, states will have pre-paid too great an amount. For families that use greater than the average amount of care, states would need to create another mechanism to pay additional funds to the family. The state of Oregon has submitted a draft Title XXI State Plan amendment that proposes this approach for the private-coverage buy-in portion of the program. HCFA has not yet indicated whether this approach will be acceptable (see state examples below).

3. **Carrier-Administered Wrap-Around.** Under this option, carriers serving employers participating in the buy-in program would agree to develop and administer a supplemental cost-sharing plan for eligible workers and/or their dependents. For example, in the case of a Title XXI buy-in program, this supplemental plan would include no co-pays on well-baby visits and other preventative services, standard Medicaid copays on all other services, and an automatic “shut-off” of copays once a family had reached the 5 percent overall cost-sharing maximum. Although the rest of the employer group would enroll in the employer’s normal coverage, workers and/or dependents eligible for the buy-in program would be enrolled in the enhanced plan instead, with the state paying the cost of the extra benefits or cost-sharing wrap-around. To administer such a wrap-around, carriers would most likely need to create a different group number for workers and dependents participating in the buy-in program, versus employees of the same group who are not participating. (No state has yet sought federal permission to use this approach under a Title XXI or Medicaid buy-in program.)
4. **Single Supplemental Carrier.** If the carrier providing the employer-based coverage does not wish to (or is unable to) administer a wrap-around, states might retain a single additional carrier to administer supplemental benefits and cost-sharing fill-ins. This is similar to the provider-state billing approach, except that providers would be billing a carrier for cost-sharing, rather than billing the state. The supplemental carrier approach may be preferable in situations where a large number of providers contracting with employer-based plans generally do not also serve the Medicaid program directly. In such situations, the Medicaid program would not be able to pay providers through the MMIS and would need to develop other payment mechanisms. In contrast, a supplemental carrier or intermediary with established relationships with private, mainstream providers may already have systems in place to contract with and pay such providers.

As is the case with state-provider billing, one of the concerns with this approach is that it would require buy-in program participants to carry two health plan cards: one for the majority of the benefits, and one for any supplemental benefits and/or cost-sharing wrap-arounds the state must purchase. This may cause confusion for families and for providers’ billing offices. (However, it should be noted that many states currently use such dual-card systems under the Medicaid Health Insurance Premium Payment program.)

HCFA has approved the single supplemental carrier approach for Mississippi’s Title XXI buy-in program (see state examples on page 46).

Table 3 lists each of the above four options and the major parties involved in their administration. The table describes how each option would impact the relevant parties in terms of ease of administration and indicates in which states each option is either being used or has been proposed. Graphic illustrations of Options 1 through 4 are included as Appendix F.

E. Title XXI-Specific Wrap-Around Options

There are a number of other options for administering a cost-sharing wrap-around that are *only* relevant to buy-in programs funded with Title XXI dollars. These options address the specific

Title XXI requirement that families with incomes over 150 percent FPL may not spend more than 5 percent of their income on children's cost-sharing. It is likely that only a very small number of children will ever exceed the 5 percent of income maximum, thus allowing this issue to be addressed with more ad hoc solutions than the general cost-sharing wrap-arounds discussed above. Analysis by the Institute for Health Policy Solutions suggests that under typical commercial HMO benefit packages, such as the ones offered by most employers, fewer than 0.2 percent of children would spend more than 5 percent of income on cost-sharing.⁴⁹ For a review of options that address this Title XXI-specific issue, the reader is referred to a paper titled "Coordination of Title XXI Coverage with Employer-Based Coverage through Consumer-Choice Health Purchasing Groups," by the Institute for Health Policy Solutions.⁵⁰

Table 3: Options for Administration of a Cost-Sharing Wrap-Around Under a Private Coverage Buy-In Program, Simplicity/Ease for Various Parties

OPTION	FAMILY	PARTY INVOLVED			WHERE IS IT BEING USED?
		STATE	PROVIDER	CARRIER SERVING THE EMPLOYER	
1. Vouchers, or Provider-State Billing	Requires family to bring vouchers to appointments and to use them; alternately, requires family to carry two identification cards	Requires development of new administrative structure to distribute and redeem vouchers and/or to pay providers. If providers are to be paid through the state's existing Medicaid Management Information System, requires all providers to have Medicaid I.D. numbers	Requires providers to submit vouchers or bills to the State for reimbursement; requires "split billing" to employer's carrier and to State	Most simple – likely requires no action on the part of the carrier	MA (in place) WI (approved)
2. Cash	Requires family to refrain from spending cash on other (potentially necessary) items; otherwise simple for family	Requires development of actuarial estimate of appropriate cash value; also requires distribution of cash to families	Most simple – requires no action on the part of the provider	Most simple – requires no action on the part of the carrier	OR (proposed)
3. Carrier-Administered Cost-Sharing Wrap-Around	Most simple	Most simple	Simplicity/ ease depends on arrangement with contracting carrier; likely will not require split billing	Requires administration of new benefit plan and creation of new "group number" for small number of people	No state at this time
4. Supplemental Carrier	May require presenting two health plan cards	Relatively simple, but requires separate contract, administration, and expenses for extra plan/carrier	May often require "split billing" to employer's carrier and to supplemental carrier	Requires coordination of benefits among carriers	MS (approved)

State Examples:

SUPPLEMENTING COST-SHARING REQUIREMENTS

Massachusetts. Under the MassHealth Family Assistance Program, providers are required to bill the state directly for any cost-sharing amounts that they may not collect from participants. Families receive a supply of forms for providers to bill the state for well-child and well-baby cost-sharing. When a person receives services from a provider, he presents his employer-based health plan ID card, which tells the provider what the cost-sharing amount is for the employer's plan. For well-child or well-baby visits, rather than paying this cost-sharing amount, the person can give the provider the billing form with instructions to bill the state. As a fail-safe, if a provider will not accept the state's billing form, or if the person fails to give the form to the provider, individuals can submit cost-sharing receipts to the state for reimbursement using the same form as is used by providers. The state will pay provider bills from a system that is separate from the Medicaid Management Information System.

In addition, the state conducts training for providers to educate them about cost-sharing under the MassHealth Family Assistance Program. Program officials contend that because most of the providers in the state are already MassHealth providers (under the public program), they already have systems in place to train these providers and to require them to comply with the Family Assistance Program rules. The MassHealth Family Assistance Program has only been in operation since August of 1998, so it is too soon to determine whether this system of supplementing cost-sharing will be successful. To date, the state has not received any cost-sharing bills from either providers or participants.

Mississippi. Under its Title XXI private coverage buy-in program, Mississippi intends to use a single supplemental carrier to administer a cost-sharing wrap-around. Providers will submit bills to the employer's carrier first and then bill the supplemental carrier for any unpaid amounts (there will be no participant cost sharing). Presumably, participants will be required to carry two health plan identification cards.

Wisconsin. Under the BadgerCare private coverage buy-in program, participant cost sharing will be handled in the same manner as it is under the state's Medicaid HIPP program. Participants will receive a BadgerCare I.D. card from the state and will be required to obtain care from Medicaid-enrolled providers (i.e., participants must choose providers who contract with both the employer-based plan and Medicaid).⁵¹ Before receiving services from a provider, a participant will present the BadgerCare card. The card will indicate that, as is the case under Medicaid, the patient may not be charged for any cost sharing. The card will also indicate that employer-based coverage is primary. The provider may obtain further information about the employer-based plan from the patient or from the BadgerCare program. The provider will then bill the employer's carrier for the services. Only after payment is received from that carrier may the provider bill the state for the balance, including applicable cost-sharing.

State Examples:

SUPPLEMENTING COST-SHARING REQUIREMENTS

Oregon. State officials are currently developing a Title XXI State Plan Amendment that will allow the state to draw down Title XXI funds for eligible children enrolled in the Family Health Insurance Assistance Program (FHIAP). State officials are proposing to use the cash method described above to supplement participants' employer-based coverage. Under this method, families would receive additional funds to cover actuarially projected cost-sharing obligations at the same time and in the same manner as they receive their premium subsidy payments. Officials in Oregon favor this approach because it is simple for families and does not require providers either to be Medicaid-enrolled or to bill a number of different entities. In addition, participant confidentiality is a priority for Oregon policy-makers. This approach does not require the participant to identify him or herself as a person receiving a subsidy. From the provider's perspective, a FHIAP participant will look just like any other member of the employer group. He or she will have a single health plan identification card (from the employer's carrier) and will pay the same cost-sharing as any other member of the group.

4. ADMINISTERING SUBSIDIES ⁵²

For states to use public funds to buy into private insurance, they must develop mechanisms to actually pay these funds to enrollees — a task that is not required under Medicaid or Title XXI. Most states will not, therefore, have mechanisms already in place to carry out this administrative function. There are essentially four ways a state can pay out the subsidy under a buy-in program. States can make subsidy payments to:

- employees/participants;
- employers;
- insurance carriers (or TPAs for self-insured employers); or,
- intermediaries, such as purchasing groups or brokers.

In thinking about subsidy administration, state officials should consider the extent to which the program must depend on the voluntary cooperation of employers, carriers, and others who do not directly benefit from the buy-in program. Officials should also consider issues such as participant confidentiality and the potential for misuse of subsidies, or fraud.

A. Making Subsidy Payments Directly to Employees/Participants

The only option for subsidy administration that does not breach participant confidentiality is to pay the subsidy directly to the participant. In most cases where employers provide health insurance as a benefit, the employee contribution toward coverage is deducted from the employee's paycheck, either on a pre- or post-tax basis. Under this option, the employer would continue to deduct the standard employee portion of the premium from the employee's paycheck, just as the employer does for all other employees. The state would then pay the employee for a portion of this expense. This approach would be invisible to the employer.

One potential problem with this approach is that it may cause cash flow difficulties for participants who have employee contribution deductions taken from their paychecks before the state makes its subsidy payment. To address this potential problem, the state could pre-pay the employee the first month's subsidy amount, before the first payroll deduction is made. In other words, prior to the first payment being deducted from the employee's paycheck, the state would send the employee a check for the subsidy amount. While states may have reservations about pre-payment before proof of enrollment, they may also be concerned about a structure in which families are reimbursed (rather than pre-paid) for premium contributions, as such an arrangement might be seen as a barrier to enrollment in the plan. Although this approach may raise concerns about misuse of subsidies (i.e., employees might accept the subsidy and then not enroll in the health plan), the risk is probably minimal, as well as unavoidable. In addition, such misuse would be a concern only in the first month of enrollment. At the end of the first month (and at the end of every subsequent month), the employee would submit a copy of a pay-stub to the state showing that the employee contribution had been deducted. If the state did not receive this proof of continuing enrollment in the health plan, the state would not send another subsidy check to the family.

If states choose this option for administering subsidies, they must develop an administrative mechanism for writing and distributing checks to potentially thousands of participants on a monthly basis. This function can be expensive. Buy-in programs may be able to save money in this area by taking advantage of existing state structures to make payments to individuals. For example, the buy-in program could contract with the state's cash assistance program for this function. Alternately, buy-in programs could contract with a private administrator, such as a payroll firm.

Chapter Highlights:

■ Private coverage buy-in programs must develop a system to deliver subsidies to participants. States may wish to pay subsidies directly to participants, to employers, to insurance carriers, or to other administrative intermediaries.

■ This chapter describes the pros and cons of making subsidy payments to each of the above parties. Issues include: participant cash-flow concerns, participant confidentiality, the potential for fraud or misuse of subsidies, and administrative burdens.

■ State examples are provided.

Operational Question:

How will the State administer subsidy payments?

Payments may be made to:

- Participants
- Employers
- Insurance carriers
- Other intermediaries

Issues to consider:

- Participant cash-flow concerns
- Participant confidentiality
- Potential misuse of subsidies
- Administrative burdens on various parties

B. Making Subsidy Payments to Employers

It may be less administratively burdensome for states to make subsidy payments to employers, simply because there may be fewer participating employers than employees. (However, such an approach clearly will not work for states wishing to buy into individual coverage.)

Under this scenario, the employer would modify the premium contribution amount that is normally deducted from the employee's paycheck. The employer would reduce the employee's payroll deduction by the amount of the subsidy received and remit the entire premium payment (including subsidies) to the carrier along with premiums for all the other employees. A major drawback to this approach is that employers may be unwilling or unable to make this change in the payroll deduction system for only a few employees. In addition, depending on state policies, changes to payroll deduction amounts could vary among employees with different incomes and numbers of children and could also vary over time with changes in employees' income.

More importantly, under Title XXI programs, employers may balk at assisting employees who had not contributed toward their children's coverage and not assisting their (same wage-level) co-workers who had. Generally, employers do not wish to be viewed as unfairly discriminating amongst their employees. In addition, this approach requires that the employer know the employee is participating in the buy-in program and also provides the employer with information about the family-income-based subsidy. While employers know a worker's wage, they do not typically have information about total family income. Some employees may not be comfortable with this lack of confidentiality and may view it as a barrier to participation.

There is also some risk of misuse of subsidies if payments are made to employers. Certain employers may accept the payments and then fail to adequately adjust the employees' payroll deductions accordingly. Again, the best way for a state to protect itself against this kind of misuse is to require employees to submit monthly pay-stubs, showing that the appropriate deduction has been taken. Alternately, it could be the employer's responsibility to submit this verification. However, states must be careful not to place too many administrative requirements on employers, or they may be unwilling to participate.

Finally, the risk of crowd-out of employer contributions may be greater if the employer receives the subsidy directly. When employers receive a check from the state, they will be acutely aware of the fact that public funds are available for their employees' coverage. They will understand the extent to which altering their contribution policies would be an advantage to them because they will know exactly how many of their employees are participating in the buy-in program.

C. Making Subsidy Payments to Insurance Carriers or Third-Party Administrators

A third alternative is for states to make subsidy payments directly to the insurance carrier or third-party administrator (TPA) in whose plan the participant is enrolled. If the participant had employer-based (as opposed to individual) coverage, the employer would be required to reduce the employee's payroll deduction amount by the amount of the subsidy. The employer would remit the employer and reduced employee contributions to the carrier. The carrier would receive the remaining premium from the state.

Because this option may require employer participation, it still raises concerns regarding participant confidentiality and employers' administrative burden. In addition, insurance carriers and TPAs may not be willing to accept premiums from two different sources for some of the members of an employer group. Such an arrangement could cause accounting and administrative difficulties for carriers. States considering this approach should discuss it with several large carriers to assess their willingness and ability.

D. Making Subsidy Payments to Other Intermediaries

States may wish to contract with an outside party to collect premium contributions from employees and employers, combine them with state-provided subsidies, and remit the total premium to the appropriate insurance carriers. Such third parties could include insurance agents and brokers, consumer-choice health purchasing groups, business associations, etc. Such an approach may work well in states where employers tend to purchase health insurance through these types of intermediaries. In the near future, the MassHealth Family Assistance Program will implement this type of approach by contracting with entities called Billing and Enrollment Intermediaries serving small employers in the program (see state examples below).

State Examples:

ADMINISTERING SUBSIDIES

Oregon. Under the state-only Family Health Insurance Assistance Program (FHIAP), the state makes subsidy payments directly to participants. (State officials will also propose this same method of subsidy administration for the Title XXI tie-in portion of the FHIAP.) Officials favor this method because it is consistent with the policy objective of maintaining participant confidentiality. By making payments directly to families, the state can avoid informing either the employer or the carrier that a given person is receiving a subsidy. State officials report that the administrative cost associated with making payments directly to participants is \$1.82 per member per month.

State officials were concerned about creating cash-flow difficulties for participants who might have to pay premiums before the state made its subsidy payment⁵³. As a result, the FHIAP pre-pays the first month's subsidy before receiving proof that the participant has enrolled in a health plan. In subsequent months, the participant must send the state proof of health plan enrollment before receiving the subsidy check. Although officials were somewhat concerned about fraud, they recognized that they were only placing the program at risk for losing the first month's premium. Early results from the program indicate that the number of individuals receiving a subsidy and failing to enroll in a health plan is extremely low. To the extent that this has occurred, officials suspect it has been due to oversight, rather than intentional fraud (i.e., the individual changed jobs or dropped coverage but didn't inform the FHIAP in time to stop the next subsidy payment). In most such cases, individuals who received inappropriate payments have voluntarily sent the funds back to the FHIAP. In budgeting for the program, FHIAP officials set aside 5 percent of the total first-year budget to offset the loss of any funds due to fraud or inappropriate payment. To date, officials do not believe they will need to use any of these offset funds.

Wisconsin. Under the BadgerCare private coverage buy-in program, state officials will develop systems to pay subsidies directly to carriers, employers, or employees. The method used to pay the subsidy for a given person will depend on how that person's employer-based plan is administered. If the employer takes the employee premium contribution directly from the employee's paycheck, the subsidy will be paid to the employee. In other cases, the subsidy will go directly to the employer or carrier. Wisconsin officials do not currently plan to pre-pay any subsidies before proof of enrollment in the health plan is received.

State Examples:

ADMINISTERING SUBSIDIES

Massachusetts. The MassHealth Family Assistance Program also makes subsidy payments directly to participants. As is the case in Oregon, families are pre-paid the subsidy amount. The state conducts a quarterly audit to determine whether families receiving subsidies have used them to enroll in the health plan. In addition, on a monthly basis, officials match program eligibility files against the enrollment files of several of the state's largest commercial carriers. This data match provides a secondary means of determining whether or not families receiving a subsidy continue to enroll in coverage (although not all carriers in the state provide enrollment data). Because the Family Assistance Program is new, data are not yet available on the extent to which families receiving a subsidy fail to enroll in coverage.

In the near future, the state will switch to a method of administering subsidies through Billing and Enrollment Intermediaries (BEI). (Recall that a number of features of the MassHealth Family Assistance Program are unique to the state's Section 1115 Medicaid waiver. In particular, the state can assist small employers with their share of workers' premiums under the Insurance Partnership program. This unique feature influences the administrative design described below.)

BEIs are entities, similar to insurance agents, that not only sell coverage to small employers, but also provide ongoing administrative functions, such as premium billing, enrollment, and disenrollment. Many small employers in Massachusetts already use BEIs. The new system will work as follows:

- The state will partner with BEIs to administer subsidies for program participants employed by small employers. The small employers will also receive subsidies through the Insurance Partnership program.
- The BEIs will collect premium contributions from small employers (and their employees). They will also have access to a bank account established by the state, from which they will withdraw funds to cover both premium subsidies and Insurance Partnership payments.
- Because premium subsidies and Partnership payments will be collected by the BEIs and remitted directly to insurance carriers, employers and employees will owe less for their insurance than they would if they were being paid directly by the state. In other words, the amounts collected by the BEIs will offset what the employer and employee would otherwise owe the insurance carrier. As a result, BEIs will need to calculate the reduced premium owed by the employer and employee and bill them appropriately.
- In situations where employers take employee premium contributions directly out of employees' paycheck, they will have to modify this deduction to account for the reduced amount owed by program participants. This represents an administrative burden for small employers because they will have to take a different deduction from the paychecks of program participants than they will take from other employees' paychecks. However, Massachusetts officials believe small employers will be willing to make this accommodation in exchange for receiving the employer subsidy through the Insurance Partnership program.

By partnering with BEIs, MassHealth officials can use a single mechanism to administer both participants' subsidies and small employer Insurance Partnership payments. In addition, this system does not require participants to provide ongoing proof of health plan enrollment. The BEIs will be responsible for verifying enrollment with the carrier. Family Assistance Program participants who are employed by non-small employers or by small employers who do not contract with BEIs will continue to receive subsidies directly from the state.

5. CONSUMER-CHOICE HEALTH PURCHASING GROUPS

One way to simplify the administration of a private coverage buy-in program is to make use of an existing consumer-choice health purchasing group (CHPG). Such purchasing groups exist in a number of states, although their structures vary considerably.⁵⁴ In general, CHPGs negotiate for and buy a limited number of standardized benefit plans from competing carriers on behalf of a large number of different employers. They also allow workers and their families to choose and enroll in any of the plans they offer (within given rules). As a result, they have administrative structures that facilitate contracting with a number of insurance carriers, collecting premiums from multiple sources, enrolling families in their choice of health plans, and making premium payments to the appropriate carriers for the duration of enrollment.

Private coverage buy-in programs that provide premium subsidies through CHPGs could have large advantages over programs that attempt to coordinate with employer-based coverage in the open market. By partnering with a CHPG, states could simplify a number of administrative functions:

- **Marketing.** CHPGs could assist states by including information about the buy-in program in employer and employee information packets.
- **Gathering information about employer contribution levels.** Most CHPGs require employers to contribute at least a minimum amount toward coverage in order to purchase through the CHPG. CHPGs may therefore already have systems in place to gather information on employer contribution levels and track changes over time. States concerned about crowd-out of private coverage can use this information to determine the effectiveness of crowd-out prevention measures (firewalls). In addition, this information is necessary in determining the cost-effectiveness of buying into private coverage (see Section II(A)(6) – Cost-effectiveness and Family Coverage).
- **Certifying plans as meeting program requirements.** Because CHPGs offer only a limited number of standardized plans, it would be simple for a state to work with a CHPG to determine whether the plans met criteria related to actuarial equivalency, benefits, and cost sharing. By certifying the CHPG's plans, the state would *de facto* be certifying coverage offered by any employer purchasing through the CHPG. As a result, it would not be necessary to gather benefits and cost-sharing information from employers. It also would not be necessary to perform actuarial analysis of each employer's plan.
- **Supplementing employer-based plans that do not meet program requirements.** If the CHPGs plans did not meet the program requirements, the state could develop a limited number of “wrap-around” packages that, when added to the CHPG's plans, would bring the coverage into compliance. In the open market, states would have to design such wrap-arounds on a case-by-case basis. In a CHPG, states could perform this function only once for all participating employers and their employees.
- **Administering benefits and cost-sharing upgrades.** As discussed in section II(B)(3) – Supplementing Benefits and Cost-Sharing Provisions, there are a number of options for states to administer supplements to employer-based coverage. Perhaps the simplest approach, from the perspective of the family and the state, is to have the employer's insurance carrier administer the upgrade. However, in the open market, it would be difficult (if not impossible) for states to develop this kind of partnership with any given carrier with whom an employer may contract. However, CHPGs only contract with a limited number of carriers. It may therefore be possible for the state and a CHPG to work with those carriers to develop a plan for the carriers to administer the upgrade.

Chapter Highlights:

- States may be able to simplify many of the tasks involved in administering a private coverage buy-in program by partnering with a consumer-choice health purchasing group (CHPG).
- CHPGs negotiate for and purchase a limited number of standardized benefit plans from competing carriers on behalf of a large number of employers.
- This chapter describes the ways in which a CHPG could assist a state in administering a buy-in program.

- **Administering subsidies.** CHPGs collect premiums from a large number of employers and remit them to competing carriers. As a result, they have administrative systems in place to track premiums from multiple sources. States may be able to take advantage of such systems to collect employer and employee contributions, combine them with state subsidies, and remit the total premium to the appropriate carrier.
- **Determining cost-effectiveness.** In most cases, CHPGs require participating carriers to use standardized rating tiers and to offer the same set of premiums to all employers (sometimes with adjustments for factors such as age, geography, etc.). Because of this standardization in pricing, it would be possible for states to determine upfront what level of employer contribution would make the buy-in cost-effective for each carrier and benefit plan offered by the CHPG.

States considering a private coverage buy-in program may wish to partner with a CHPG on a pilot basis. The state of Oregon will propose such a pilot program in its Title XXI State Plan amendment (to be submitted to HCFA in the spring of 1999). State officials can obtain information about CHPGs in their states by contacting the Academy of Consumer-Choice Health Purchasing Groups at the Institute for Health Policy Solutions.⁵⁵

III. Resources

This section lists the resources cited throughout the Guide, in addition to other resources states may find useful. Resources are listed by topic. Those that address multiple topics are listed in multiple places.

A. General Useful Web Sites

Most of these organizations maintain extensive lists of publications, many of which are available on-line.

1. Institute for Health Policy Solutions

- To contact the author of this Guide:

Laura Tollen, Senior Analyst
 Institute for Health Policy Solutions
 1444 I St., NW, Suite 900
 Washington, DC 20005
 (415) 331-2763
laura.tollen@mindspring.com

- For information on the Child Health Initiatives Resource Center or the Academy of Consumer-Choice Health Purchasing Groups, see www.ihps.org or call (202) 857-0810.

2. **Alpha Center**, www.ac.org.
3. **Center on Budget and Policy Priorities**, www.cbpp.org.
4. **David and Lucile Packard Foundation** (see “Children, Families, and Communities”), www.packfound.org.
5. **Health Care Financing Administration** (U.S. Department of Health and Human Services), for all Medicaid and Title XXI State Plans, correspondence, and additional information, www.hcfa.gov.
6. **Kaiser Commission on Medicaid and the Uninsured**, www.kff.org/archive/rowland.html.
7. **National Governors’ Association Center for Best Practices**, www.nga.org/CBP/.
8. **National Academy for State Health Policy**, www.nashp.org.
9. **National Association of State Medicaid Directors**, <http://medicaid.aphsa.org>.
10. **The Robert Wood Johnson Foundation**, www.rwjf.org.
11. **Urban Institute, Assessing the New Federalism Project**, <http://newfederalism.urban.org>.

B. State-Specific Information

1. **Massachusetts** (MassHealth Family Assistance Program)

- Donelan, K., et al, *A Survey of the Health Insurance Status of Massachusetts Residents*, Department of Health Policy and Management, Harvard School of Public Health, Cambridge, MA, October 1995.
- Hearne, J., *HHS Approves Massachusetts Premium Assistance for Employer-Sponsored Insurance*, Institute for Health Policy Solutions, for the David and Lucile Packard Foundation, Washington D.C., June 1998, www.ihps.org/Plan%20Approved.htm.
- Massachusetts Title XXI State Plan, Fact Sheet, and Additional Materials, Health Care Financing Administration, www.hcfa.gov/init/chipma.htm.
- Massachusetts Executive Office of Health and Human Services, Division of Medical Assistance, www.state.ma.us/dma.

2. **Minnesota** (MinnesotaCare)

- Call, K., N. Lurie, Y. Jonk, R. Feldman, and M. Finch, "Who is Still Uninsured in Minnesota? Lessons from State Reform Efforts," *Journal of the American Medical Association*, V278, N14, October 1997, pp. 1191-1195.
- Minnesota Department of Human Services – MinnesotaCare, (includes Title XXI information), www.dhs.state.mn.us/hlthcare/AsstProg/mncare.
- Sexton, J., *MinnesotaCare and "Crowding-Out,"* Institute for Health Policy Solutions, for the David and Lucile Packard Foundation, Washington D.C., September 1998, www.ihps.org/9-98Sex.PDF.

3. **Mississippi**

- Mississippi Title XXI State Plan, Amendment, Fact Sheet, and Additional Materials, Health Care Financing Administration, www.hcfa.gov/init/chipms.htm.
- Mississippi Division of Medicaid (includes Title XXI information), www.dom.state.ms.us.
- Mississippi Department of Finance and Administration, Insurance Office, State and Public School Employees Health Insurance Management Board (the agency that will administer the Title XXI program), www.dfa.state.ms.us/insurance/insurance.html.

4. **Oregon**

- Office of Oregon Health Plan Policy and Research, www.ohppr.state.or.us.
- Oregon Department of Human Resources, Office of Medical Assistance Programs, www.omap.hr.state.or.us.
- Sexton, J., *An Overview of the Oregon Family Health Insurance Assistance Program*, Institute for Health Policy Solutions, for the David and Lucile Packard Foundation, Washington D.C., December 1998, www.ihps.org/12-98Sex.htm.

5. **Wisconsin** (BadgerCare)

- Wisconsin Title XXI State Plan, Amendment, Fact Sheet, and Additional Materials, Health Care Financing Administration, www.hcfa.gov/init/chipwi.htm.
- Wisconsin Department of Health and Family Services (see “BadgerCare Final Approved Program Summary”), www.dhfs.state.wi.us.

C. Trends in Health Insurance Take-Up Rates/ Reasons for Declining Coverage

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2. Perry, J., E. Stark, and R. Burciaga Valdez, *Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings from Eight Focus Groups in California with Parents of Potentially Eligible Children*, Henry J. Kaiser Family Foundation, Menlo Park, CA, September 1998.
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2. National Association of State Medicaid Directors (American Public Human Services Association) description of programs in each of the Section 1115 waiver states, <http://medicaid.aphsa.org/1115waivers.htm>.

Appendix A:

Section 1931 and State Flexibility in Determining Medicaid Eligibility

Section 1931 of the Social Security Act, included under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), gives states expanded flexibility in defining what counts as income and resources for purposes of Medicaid eligibility determination. Prior to the passage of PRWORA, Medicaid eligibility for families was largely tied to receipt of Aid to Families with Dependent Children. The PRWORA makes a number of changes to welfare eligibility rules, many of which have resulted in fewer families being eligible for cash assistance. However, the law also “de-links” Medicaid and cash assistance eligibility, creating a category of “Medicaid-only” eligibles.

Under the law, families that meet their state’s July 1996 AFDC income and resource standards qualify for Medicaid coverage, whether or not they qualify for welfare benefits. Section 1931 allows states flexibility in determining whether people meet the July 1996 standard by permitting them to apply more liberal means of counting income and resources for this “Medicaid-only” category. (Section 1931 is parallel to the longer-standing Section 1902(r)(2), which permits states to use liberal means of counting income and resources for certain groups of Medicaid eligibles, such as poverty-level children and aged, blind, and disabled groups.)

Federal law requires Medicaid programs to disregard certain types and amounts of income when determining a family’s Medicaid eligibility. For example, states must disregard \$90 per month in earnings to help families cover certain work-related expenses such as transportation.⁵⁶ As a result, although a family’s true income might be \$400 per month, its “countable” income, for purposes of Medicaid eligibility, would only be \$310. Section 1931 allows states greater flexibility in defining such income disregards, thus increasing the likelihood that working individuals may qualify for Medicaid. A policy brief by the Center on Budget and Policy Priorities provides a useful example:

Consider a state that covers a mother with two children if her countable income falls below the state’s July 16, 1996, income standard of \$463 per month (or about 41 percent of the federal poverty line). If the state wants to expand Medicaid to working parents with income below the federal poverty line (\$1,138 a month for a family of three in 1998), it could establish a larger disregard for earned income. If it adopted an earned income disregard of \$676 per month, a family of three with earnings at the poverty line would be treated for purposes of Medicaid eligibility as having countable income of \$462 a month ($\$1,138 - \$676 = \462). The family, therefore, would be eligible for Medicaid under the state’s July 16, 1996 income standard of \$463 a month.⁵⁷

Rhode Island is one of few states that has taken advantage of Section 1931 for Medicaid-only (non-AFDC) eligibles. That state is using Section 1931 to provide coverage for the parents of children covered RiteCare, the state’s Section 1115 Medicaid waiver program. Children are eligible for RiteCare at income levels up to 250 percent of the federal poverty level (FPL) with no resource test. Rhode Island has used the flexibility provided under Section 1931 to expand eligibility to parents of eligible children up to 185 percent FPL and with no resource test. The state disregards parents’ assets and any income between the previous eligibility levels (tied to AFDC) and 185 percent FPL.

One of the advantages to states of using Section 1931 to modify Medicaid eligibility policies is that federal approval is not required. States can access the provisions of 1931 simply by filing a Title XIX (Medicaid) State Plan amendment with the Health Care Financing Administration (HCFA). Such an amendment can be effective as soon as it is filed (or even retroactively back to the first day of the quarter in which it was filed, if the state so chooses). In contrast, states that wish to expand Medicaid eligibility through a Section 1115 Research and Demonstration waiver must apply for permission to do so. The 1115 waiver approval process can take many months (or years).

HCFA has provided states with information about the implications of PRWORA (including Section 1931) for health care coverage of low-income families. This information can be found in two official letters from the federal agency, dated September 22, 1997, and March 22, 1999.⁵⁸

Appendix B:

Sources of Data Regarding the Target Population and the State's Insurance Market

SOURCE	TYPE OF INFORMATION AVAILABLE	WHERE TO FIND IT
<p>Current Population Survey, U.S. Bureau of the Census (March CPS)</p>	<p>The Annual Demographic Survey, or March CPS supplement, is the primary source of detailed information on income and work experience in the United States. Numerous publications based on this survey are issued each year by the Bureaus of Labor Statistics and Census. A public-use microdata file is available for private researchers.</p> <p>Data are available on insurance status by age, family size, income, employment status, etc., although sample size for a given state may be small. States will likely need to use a several-year merge of data.</p> <p>The CPS does not include data on whether or not people were offered employer-based insurance.</p>	<p>For a recent summary of major health insurance findings, see: Bennefield, R., <i>Current Population Reports – Health Insurance Coverage 1997</i>, Census Bureau, U.S. Department of Commerce, Economics and Statistics Administration, September 1998 (P60-202).</p> <p>General information about the Current Population Survey is available at: www.bls.census.gov/cps/ads/adsmain.htm</p> <p>In addition, select CPS variables (including health insurance status variables) are available (by state) under the Urban Institute's <i>Assessing the New Federalism</i> State Database (see below, this table), and on the Alpha Center web site at http://www.ac.org/httpdocs/stateinfo.html.</p>
<p>Medical Expenditure Panel Survey</p>	<p>The current (1996) MEPS is the third in a series of medical expenditure surveys conducted by the Agency for Health Care Policy and Research. It is a nationally representative survey that collects detailed information on the health status, health care and expenses, and health insurance coverage of individuals and families in the United States.</p> <p>As does the CPS, the MEPS provides information on insurance status by age, family size, income, employment status, etc. MEPS also has information on whether or not individuals are offered employer-based insurance and on what they pay for their coverage. This information has not yet been released but will be available shortly.</p> <p>The MEPS is more useful for national, rather than state-level, data. The entire sample is approximately 25,000 people. Accordingly, the sample size for any given state is small. In addition, unlike the CPS, the MEPS is not conducted annually, so states will not be able to increase the sample size by merging several years' worth of data.</p>	<p>Public-use files are available from the U.S. Department of Health and Human Services – Agency for Health Care Policy and Research, http://www.meps.ahrpr.gov.</p>

SOURCE	TYPE OF INFORMATION AVAILABLE	WHERE TO FIND IT
<p>1993 Robert Wood Johnson Foundation Family and Employer Health Insurance Surveys</p>	<p>Employer Survey: A 1993 survey of approximately 2,000 employers in each of ten states. The purpose of this survey was to investigate the barriers to the provision of employer-sponsored health insurance coverage and to describe the premiums and other characteristics of health plans offered by employers. The survey collected data on characteristics of employers and workers in establishments offering and not offering health insurance, including the number of employees (statewide and nationwide), the distribution of workers by hours worked, age, sex, and earnings, the peak month for seasonal workers, the type of industry or business, whether health insurance was offered, and eligibility rules for health insurance. It also collected information about the characteristics of plans offered, including premiums, cost sharing, medical underwriting, self-insurance, type of plan, number of days a person must wait for coverage of a pre-existing condition, and whether each plan covered prenatal care, maternity care, prescription drugs, mental health services, dental care, and treatment for alcohol or drug abuse.</p> <p>Family Survey: A 1993 survey of approximately 2,000 families in each of ten states. This survey investigated health insurance coverage, as well as access to and use of health services. The main unit of observation is the "health insurance family," which includes the head, spouse, and their children up to age 18, or to age 23 if they were in school. Variables on health insurance coverage include the types of coverage respondents carried (Medicare, Medicaid, additional state or federal programs, and private policies), sources of private policy coverage, premiums paid for private individual policies, and number of months uninsured during the last year. The survey also included variables regarding access to and utilization of health care services. The survey elicited self-reported health status, gauged satisfaction/dissatisfaction with health services received, and gathered information on employment, income, education, migration, age, sex, marital status, race, ethnic origin, and citizenship.</p>	<p>Raw data are available for the following 10 states <i>only</i>: CO, FL, MN, NM, NY, ND, OK, OR, VT, and WA. Contact the Inter-University Consortium for Political and Social Research at the University of Michigan for both the Employer and Family survey data. (See www.icpsr.umich.edu. Follow the prompts to "archives" and "health care, facilities.")</p> <p>Data are available at no charge to member institutions. Most major research universities in the United States are members. State officials may be able to partner with a local university to access the data. Data can also be accessed by state officials for a fee. Contact ICPSR User Support for more information: (734) 998-9799, or netmail@icpsr.umich.edu.</p> <p>Summarized results of the Employer survey are found in:</p> <ul style="list-style-type: none"> ■ Cantor, J., S.H. Long, and M.S. Marquis, "Private Employment-Based Health Insurance in Ten States," <i>Health Affairs</i>, Summer 1995, pp. 199-211. ■ Acs, G., S.H. Long, M.S. Marquis, and P.F. Short, "Self-Insured Employer Health Plans: Prevalence, Profile, Provisions, and Premiums," <i>Health Affairs</i>, Summer 1996, pp. 266-278. <p>Summarized results of the Family survey are found in:</p> <ul style="list-style-type: none"> ■ Long, S.H., and M.S. Marquis, "Some Pitfalls in Making Cost Estimates of State Health Insurance Coverage Expansions," <i>Inquiry</i>, Spring 1996, pp. 85-91.

SOURCE	TYPE OF INFORMATION AVAILABLE	WHERE TO FIND IT
<p>1997 Robert Wood Johnson Foundation Employer Health Insurance Survey</p>	<p>This survey interviewed 23,545 private employers nationwide. Data are from 1997. The survey included detailed questions for firms both offering and not offering insurance to their employees. The survey was not designed to produce estimates for most states. Results of the survey began to become available in 1998.</p>	<p>Summarized results can be found in: Cantor, J., S.H. Long, and M.S. Marquis, "Challenges of State Health Reform: Variations in Ten States," <i>Health Affairs</i>, January/February 1998, pp. 191-201.</p>
<p>Urban Institute – Assessing the New Federalism State Reports</p>	<p><i>Assessing the New Federalism</i> is a multi-year research and analysis project dedicated to:</p> <ul style="list-style-type: none"> ■ Documenting the ongoing transfer of responsibility for social programs from the federal government to the states; ■ Monitoring program changes and fiscal developments; ■ Focusing on health care, income security, job training and social services; and, ■ Studying the well being of children and families in collaboration with Child Trends, Inc. <p>Among other publications, the ANF project has produced a series of reports on health, income support, and social services for a number of states. These reports are based on case studies conducted in 13 states: AL, CA, CO, FL, MA, MI, MN, MS, NJ, NY, TX, WA, and WI.</p> <p>The health reports describe the entire context of health care provision for the low-income population, including Medicaid and similar programs, state policies regarding insurance, and the role of public hospitals and public health programs. Each report describes the policies and programs in place in the base year of this project, 1996.</p> <p>The state reports are available in full-length and also in shorter versions, called "Highlights from State Reports." In addition to Highlights on the above 13 states, Highlights will also be available for: AZ, GA, IL, MD, MO, NM, NC, OK, OR, PA, and TN.</p>	<p>The state reports and highlights are available at: http://newfederalism.urban.org/html/reports.html or by contacting:</p> <p>Harold Leibovitz ANF Communications Director Phone: (202) 261-5815 FAX: (202) 293-1918 E-mail: hleibovi@ui.urban.org</p>
<p>Urban Institute – Assessing the New Federalism State Database</p>	<p>The <i>Assessing the New Federalism</i> State Database includes more than 350 variables on the 50 states and the District of Columbia, in areas including income security, health, child well-being, demographic, fiscal, and political conditions, and social services. Data were collected from a variety of state and federal sources. Full documentation is available for each variable.</p> <p>The database is available at no charge on-line and is extremely simple to use. State health officials will be particularly interested in variables on income, employment status, sources of insurance, Medicaid and TANF case-loads, etc.</p>	<p>The database can be accessed at: http://newfederalism.urban.org/nfdb/ or by contacting:</p> <p>Harold Leibovitz ANF Communications Director Phone: (202) 261-5815 FAX: (202) 293-1918 E-mail: hleibovi@ui.urban.org</p>

SOURCE	TYPE OF INFORMATION AVAILABLE	WHERE TO FIND IT
<p>Urban Institute – Assessing the New Federalism</p> <p>1997 National Survey of American Families</p>	<p>The National Survey of American Families was conducted by Westat under contract to the Urban Institute as part of the <i>Assessing the New Federalism</i> project. The survey of households was conducted in 1997 and used a sampling methodology designed to produce reliable results for the 13 ANF states (see above) and for the U.S. as a whole. A follow-up survey is being conducted in 1999.</p> <p>Respondents were asked questions related to income and hardship, children's environment and behavior, adults' environment and behavior, and health. Health-related subjects included health insurance coverage of children and adults, parents' confidence in their ability to obtain medical care for their children, the number of children and adults with no usual source of health care, and health status of adults and children.</p>	<p>Summarized information from the National Survey of American Families is available in the Urban Institute publication <i>Snapshots of America's Families</i>. An on-line version of the publication can be accessed at www.urban.org. A hard copy can be obtained by calling the Urban Institute at (202) 261-5815.</p> <p>The Urban Institute is currently in the process of developing public-use data files from the survey. Information about accessing the data will be available on the Urban Institute web site.</p>
<p>Survey of Income and Program Participation (SIPP), U.S. Bureau of the Census</p>	<p>This survey collects information on source and amount of income, labor force characteristics, program participation and eligibility, and general demographic characteristics.</p> <p>The survey design is a continuous series of national panels, with sample size ranging from approximately 14,000 to 36,700 interviewed households. The duration of each panel ranges from 2 1/2 years to 4 years.</p>	<p>Data are released periodically in cross-sectional, topical module, and longitudinal reports. Public use files, containing the core data on income reciprocity and program participation, are also available. These files are available currently for all waves of the 1984 through 1993 panels and Wave 1 of the 1996 panel.</p> <p>Public-use files and summary reports are available at: www.sipp.census.gov/sipp/sipphome.htm.</p>
<p>National Employer Health Interview Survey (National Center for Health Statistics)</p>	<p>The National Employer Health Insurance Survey (NEHIS) is a national survey of businesses in the private and public sectors. Interviews were completed for more than 39,000 businesses and organizations. The survey is sponsored by the National Center for Health Statistics, the Agency for Health Care Policy and Research, and the Health Care Financing Administration.</p> <p>Data collection began in April 1994 and ended in December 1994.</p> <p>Results include (among others): percent of establishments offering insurance, by firm size and by state; percent of establishments offering at least one health plan that self insure at least one health plan, by firm size and by state; percent of employees working in establishments that offer insurance, by firm size and by state.</p>	<p>For a summary of both national and state-level findings, see:</p> <p>U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, <i>Employer-Sponsored Health Insurance: State and National Estimates</i>, Hyattsville, MD, December 1997, DHHS Publication number (PHS) 98-1017. (available at www.cdc.gov/nchswww/products/pubs/pubd/netpubs.htm, see "other publications," then "miscellaneous publications").</p> <p>For general information on the NEHIS, see www.cdc.gov/nchswww/about/major/nehis/nehis.htm</p>

SOURCE	TYPE OF INFORMATION AVAILABLE	WHERE TO FIND IT
<p>States' Departments of Insurance</p>	<p>States' departments of insurance will be able to provide information regarding certain characteristics of the insurance market. Questions that a state's insurance department may be able to answer include:</p> <ul style="list-style-type: none"> ■ What health plans have the largest share of the private market? ■ What percent of insured employer groups have coverage through a health maintenance organization (HMO) versus another type of coverage? ■ What are typical benefits packages that employers purchase? ■ What are typical premiums for various family tiers (employee only, employee and spouse, family, etc.)? ■ What type of rating reform (if any) exists in the small group and individual markets? <p>In addition, health plans are generally required to submit detailed insurance filings to the department of insurance. Such filings include information on health plans' financial condition and the rates they charge employers and individuals.</p>	<p>Contact individual states' insurance departments.</p>
<p>Insurance Carriers</p>	<p>States may wish to conduct an ad hoc survey of several of the largest insurance carriers in relevant markets. Surveyed carriers should have either a large commercial market share or a large Medicaid market share (or both). The department of insurance can help identify the appropriate carriers to survey (see above). Questions that carriers may be able to answer include:</p> <ul style="list-style-type: none"> ■ What are average employer and employee contributions toward employee and dependent coverage? ■ What are typical benefits packages that employers purchase? ■ What are typical premiums for various family tiers (employee only, employee and spouse, family, etc.)? ■ To what extent do carriers rely on brokers and/or agents for marketing their products? Do they work with a small or large number of agents/brokers? ■ Would carriers be willing or able to administer a cost-sharing or benefit wrap-around plan for individuals participating in an employer-based coverage buy-in program? <p>Although such an <i>ad hoc</i> survey will not provide statistically valid information, it will provide state officials with a sense of the likelihood that a private coverage buy-in program will reach its target population. It may also help state officials identify carriers willing to participate in a private-coverage buy-in pilot program.</p>	<p>States' departments of insurance should be able to help identify carriers to survey. Large purchasers of health insurance (such as Medicaid programs, state employee benefit plans, and purchasing groups) might also have relevant carrier contacts.</p>

Appendix C:

HCFA Letter on Title XXI Private Coverage Buy-In Programs

HEALTH CARE FINANCING ADMINISTRATION

February 13, 1998

Dear State Health Official:

The Children's Health Insurance Program (CHIP) was created, with bipartisan support, to provide health insurance to uninsured children. The new law contains provisions explicitly designed to ensure that funds are targeted only to uninsured, and not already insured, children. Some of these provisions relate to Medicaid, while others are intended to prevent CHIP from substituting for private coverage. We are writing to provide guidance on the standards that the Department of Health and Human Services (DHHS) will use to evaluate State strategies to prevent this type of substitution of coverage. These strategies are necessary to maximize the use of Federal dollars and to provide more coverage to children who currently lack health insurance.

The Potential for Substitution

The potential for substitution of CHIP coverage for private group health coverage exists because CHIP provides reduced-price coverage that some individuals and employers currently purchase with their own funds. Specifically, employers with lower-wage employees could potentially save money if they stop offering dependent coverage (or if they reduce or eliminate their contributions for such coverage) and encourage their employees to enroll their children in the CHIP plan. At the same time, families that currently are making significant contributions towards dependent coverage (either through their employer plan or through an individual plan) could have an incentive to drop their current coverage and enroll their children in the CHIP plan as long as the benefits would be comparable and their out-of-pocket costs would be reduced. There also may be an incentive for States to substitute CHIP for Medicaid coverage, since CHIP has an enhanced matching rate.

Medicaid Substitution Provisions

Title XXI contains three provisions aimed at preventing CHIP from substituting for current Medicaid coverage. First, the State plan must include assurances that the State will coordinate its CHIP program with other public and private programs, including Medicaid. Second, there are "maintenance of effort" provisions for Medicaid eligibility. In a State that chooses to create a non-Medicaid CHIP program, the State cannot adopt income and resource methodologies for Medicaid children that are more restrictive than those in effect on June 1, 1997. In a State that chooses to create a Medicaid CHIP program, children are not eligible for enhanced matching under CHIP if they would be eligible for Medicaid in their State under the standards in effect on March 31, 1997. Third, any child who applies for CHIP must be screened for Medicaid eligibility and, if found eligible, enrolled in Medicaid.

HHS Review of Strategies to Protect Against Substitution of Private Coverage

The Balanced Budget Act of 1997 requires that States submitting applications to operate a State program with Federal funding through the Children's Health Insurance Program (CHIP) include a description of the procedures to ensure that coverage provided under CHIP does not substitute for

coverage under either Medicaid or private group health plans. DHHS will review State CHIP plans to determine if the State has included procedures designed to address any potential substitution concerns. We believe that there are two distinct cases that need to be addressed: (1) insurance coverage provided directly through CHIP or Medicaid; and (2) using CHIP funds to subsidize coverage provided through employer-sponsored group health plans.

We will apply particular scrutiny to States whose State CHIP programs furnish coverage through employer-sponsored group health plans because we believe there is a greater potential for substitution of public for existing private spending on health insurance in these types of arrangements. First, we believe that this approach may increase the likelihood that families currently covered by employer-sponsored plans will seek the publicly subsidized coverage since these families could get premium assistance while still remaining in their existing group coverage plan. Many families may be reluctant to split up their family's health insurance to cover their children through CHIP, but could be more likely to choose CHIP if they would not have to disenroll their children from their current plans. Second, employers with low-wage workers may have incentives to reduce or eliminate their premium contributions for dependent coverage if the CHIP assistance replaced that contribution. The Department will review State CHIP plan submissions as follows:

- Insurance Coverage Provided Directly through CHIP or Medicaid. States that provide insurance coverage through a children's only and/or a State plan (as opposed to subsidizing employer-sponsored coverage) or expand through Medicaid will be required to describe procedures in their State CHIP plans that reduce the potential for substitution. The crowd out concerns increase at higher levels of poverty, and the Department will be applying greater scrutiny in these cases. After a reasonable period of time, the Department will review States' procedures to limit substitution. If this review shows that they have not adequately addressed substitution, the Department may require States to alter their plans.
- Subsidizing Employer-Sponsored Group Health Plans. States that use CHIP funds to subsidize employer-sponsored group health plans should incorporate provisions in their State CHIP plan that are substantially equivalent to each of the following five provisions. We will work with States that have other methods to prevent crowd out to ensure that they are substantially equivalent to these requirements.
 1. To ensure that coverage is targeted to children in families that previously were unable to afford dependent coverage, children in a family will not be eligible for subsidies through an employer-sponsored group health plan if the family had employer-sponsored group coverage for these children within the previous six months. States will have the option to require a longer period of uninsurance, but that period could not exceed 12 months. Exceptions would be allowed if the prior coverage was involuntarily terminated (by other than a current employer). Newborns who are not covered by dependent coverage would not be subject to any such waiting period.
 2. To discourage employers from lowering their existing contributions for dependent coverage, States only will be permitted to make subsidies available for the purchase of dependent coverage through employer-sponsored group health plans in cases where the employer contributes at least 60 percent of the cost of family coverage, which is the median employer contribution nationwide. We can consider a somewhat lower level if States have additional provisions to limit employers ability to lower contribution levels. For ease of administration, the State may establish a minimum dollar employer contribution or some other method that is equivalent to the 60 percent requirement to assure that employers continue to pay a meaningful share of the costs in these programs.

3. To ensure that the provision of child health assistance through employer-sponsored group health plans is cost-effective and that the State is not inappropriately subsidizing coverage for the adults in a family, a State's payment for a child enrolled in an employer-sponsored group health plan can be no greater than the payment that the State would make for the child if they were enrolled in a separate CHIP plan offered by the State (or in Medicaid if appropriate). If the State subsidizes children's coverage only, there is no need for a State to seek a family coverage waiver under Section 2105(c)(3). If the State intends to cover any adults, however, the State must seek a waiver under this section.
4. To promote cost-effectiveness, families electing to receive child health assistance through an employer-sponsored group health plan will be required to apply for the full premium contribution available from the employer. This contribution will reduce the CHIP contribution toward the premium.
5. To demonstrate cost-effectiveness, the State will be required to collect information and conduct an evaluation that examines the amount of substitution (if any) that has occurred under the program and the effect of these provisions on access to the program. States must assess the prior insurance coverage of enrolled children. Information on prior coverage can be obtained through the enrollment process, separate studies of CHIP enrollees, or other means that reliably gather information about prior health insurance status. To determine the level of substitution, States are encouraged to analyze the number of families who choose to enroll in CHIP who might have retained or bought private insurance had they not received CHIP funding for employer-sponsored insurance. States will conduct this evaluation within a specified time period. Based on the State evaluations, the Department will reevaluate its position on these requirements for States that subsidize employer-sponsored group health plans.

States that choose to subsidize children's coverage through employer-sponsored group health plans would report in their State Child Health Plan their compliance with these guidelines. Including this information in the Plan will be deemed as meeting the requirement in the law that insurance provided under the State child health plan does not substitute for coverage under group health plans.

Summary

This guidance is intended to contribute to our national goal that CHIP provides coverage to uninsured children rather than children who are already covered.

Sincerely,

Sally K. Richardson
 Director
 Center for Medicaid and State Operations
 Health Care Financing Administration

Claude Earl Fox, M.D., M.P.H.
 Acting Administrator
 Health Resources & Services Administration

Appendix D:

Primer on Private Insurance Market Rating Practices

The Nature of Risk: Groups versus Individuals

Insurance carriers price their plans based on the expected use of services by the covered individual or group. The less carriers know about a group's or individual's expected use of services, the more risk is involved in issuing coverage. Risk can be defined as the likelihood that premiums collected will not meet the cost of services used. A person likely to use services that cost more than his premium is considered a bad risk. A person likely to use services that cost less than his premium is considered a good risk.

One way that insurance carriers limit their risk exposure is to issue coverage to groups, rather than to individuals. This practice is known as spreading risk. Although a few members of a group may be bad risks (i.e., the carrier will have to spend more for them than is collected in premiums), others are likely to be better risks (i.e., the carrier will spend less for them than is collected in premiums). By spreading risk, a carrier can ensure that there are sufficient funds to cover the care needs of a group or population. The larger the covered group, the more the risk is spread, and the less likely that the cost of the group's care will exceed total premiums collected.

In contrast, when a carrier sells insurance to an individual, there are no other group members to help absorb the risk. Therefore, if a carrier knows that a given person is high-risk (e.g., the person has a history of heart problems), the carrier must charge that person a higher premium to cover the cost of care. As a result, for many individuals with mild to severe health conditions, group coverage may be a better value than individual coverage because it will likely be less expensive and will cover more services and/or conditions.

Underwriting, Exclusions, and Pre-Existing Condition Waiting Periods

The process of basing premiums on health status or prior conditions is known as medical underwriting, and it is widespread in the individual market. It can be found to a lesser extent in small group markets and is rarely found in large group markets. Medical underwriting can also result in certain services being excluded from an insurance policy. For example, if a person has a history of depression, the insurance carrier may decide that the risk of such a person using services for depression is so great, and the cost is likely to be so high, that no amount of premium collected from the individual will suffice. The carrier may exclude this condition from the insurance policy. Alternately, the carrier may impose a pre-existing condition waiting period, during which time the covered individual may not receive payment for services related to an existing health care condition.

As a result of underwriting in the individual market, few but the healthiest, lowest-risk individuals can afford to purchase comprehensive individual coverage. Many people will have access to affordable, comprehensive coverage only if they are part of a group.

Small Group Insurance Reform

In both the group and individual insurance markets, carriers have traditionally made assumptions about likely health services utilization based on characteristics of enrollees, including age, sex, geographic location, family size, and health status (to name a few). Among individuals and small groups (i.e., groups of 50 or fewer employees), rating based on such characteristics can result in premiums that vary widely from group to group or from individual

to individual. In many states' small group markets, groups with a large proportion of older or sicker workers have been unable to find affordable coverage. To increase access to coverage for small groups, many states have enacted laws that structure small group markets in a variety of ways, including:

- ❑ Limiting the extent to which carriers can set premiums for small groups based on factors such as age, sex, and health status; and,
- ❑ Limiting or prohibiting the use of pre-existing condition waiting periods.

In addition, federal law now requires that all insurance carriers doing business in small group markets offer all their products to all small employers.⁵⁹ This guaranteed-issue requirement prohibits carriers from developing rich benefit packages they will only sell to low-risk groups, while selling less desirable coverage to high-risk groups. Instead, under guarantee issue, carriers must offer all their small group products to all small groups.

Why Insurance Market Reform Matters to a Buy-In Program

In some instances, the presence of small group and/or individual insurance market reform may provide certain advantages to states designing private coverage buy-in programs.

- **Fairness/Equity.** The presence of insurance reform can lead to more equitable treatment of employer groups in the administration of a buy-in program. For example:

Assume Employer A and Employer B each have ten employees, and both offer the same HMO benefit plan from the same carrier. Among Employer A's employees, one has high blood pressure, and another has a history of melanoma. All of Employer B's employees are healthy. In a non-reformed insurance market, Employer A will likely have to pay significantly more for coverage than will Employer B for the same plan. In a reformed market, however, the premiums charged both employers would be the same or similar. As a result, if it is cost-effective for the state to buy-into Employer A's plan, it will also be cost-effective for the state to buy into Employer B's plan. Thus, the presence of insurance reform can lead to greater fairness in the administration of a private coverage buy-in program. Individuals in like circumstances will be able to participate.

- **Administrative Simplicity.** In states using both federal and state funds to buy into private coverage, officials must assess the benefits available under a private plan to ensure that they meet federal standards. In reformed markets, where exclusions and waiting periods for pre-existing conditions are generally limited or prohibited, there is likely to be greater uniformity in the benefits purchased by groups and individuals.⁶⁰ In addition, a number of states' small group insurance reform laws establish one or more standardized plans that all small group carriers must offer. In a few states, such as Colorado, standardized plans were designed to reflect typical or popular coverage in the market and actually have significant enrollment. With greater uniformity in the benefits available in the marketplace, the state's task of assessing benefit plans for compliance with federal rules will be made simpler.

Today, almost every state in the nation has some degree of small group insurance rating reform. A number of states prohibit the use of health status as a rating factor in the small group market, and most others limit the extent to which health status can affect premiums. In contrast, significantly fewer states have rating reform in the individual market. State officials designing private coverage buy-in programs should determine the status of reform in both the group and individual markets before deciding in which market subsidies will be made available.

State Example: Oregon

SUBSIDIES FOR GROUP AND INDIVIDUAL COVERAGE

Under the Oregon Family Health Insurance Assistance Program (FHIAP), the state provides subsidies to people purchasing either group or individual coverage. Oregon has both individual and small group insurance market reform, although the rules in the small group market are more strict than in the individual market. In the individual market, carriers may rate only based on age and sex. Individual carriers may also accept or reject potential enrollees, but they may not exclude certain conditions from coverage.⁶¹ State officials have, therefore, taken a few steps to structure the individual insurance market for purposes of the FHIAP. Specifically, the state has certified a number of individual insurance carriers to participate in the program. To be certified, individual carriers must meet the following requirements (among others):

- Carriers must agree to assist in the development of a common health benefit plan for the individual market for FHIAP participants. This requirement is designed to ensure that coverage purchased from individual carriers meets at least a basic benefit level.
- Carriers must offer one or more plans that provide prescription drugs, preventive services, maternity benefits, mental health and chemical dependency treatment, and hospice and palliative care. This requirement is also designed to ensure compliance with a basic benefit level.
- Carriers must demonstrate and maintain an individual market rejection rate not to exceed 20 percent. The rejection rate is the percentage of applicants for coverage who are turned away for health reasons. Although Oregon permits its individual carriers to refuse coverage, this requirement for FHIAP certification ensures that participating carriers are not employing overly restrictive acceptance criteria.

Appendix E:

Massachusetts Employer Information Sheet

What is MassHealth?

MassHealth is the name given to a set of programs, administered by the Massachusetts Division of Medical Assistance, that either provide or help pay for health insurance for low- and middle-income people in the state, as well as people with disabilities.

What is MassHealth Family Assistance?

MassHealth Family Assistance is a program to help working people pay for health insurance offered by their employer.

I am an employer. Why are you contacting me?

One of your employees has applied for assistance from MassHealth. In order to complete the application, we need some information about any employer-sponsored health insurance that is available.

Is it okay for me to be giving out this information?

Yes. Applicants for MassHealth sign a statement, included on the application itself, which authorizes employers to release certain information to the Division. The statement reads, "I hereby authorize and direct my employer and the health insurer responsible for providing health insurance to me, my spouse, and/or my children to release to the Division of Medical Assistance any and all information pertaining to health insurance premiums, coinsurance, deductibles and covered benefits that are available."

We will not be asking for any information beyond what the employee has authorized you to release.

Who can receive assistance? **

In general, Family Assistance provides assistance to low- and middle-income persons and their families. Employees with children may be eligible to receive assistance in the purchase of their employer-sponsored health insurance without regard to the size of their employer.

** Beginning in 1999 employees without children who work for an employer with 50 or fewer full time employees may be eligible to receive assistance.

In order to be eligible to receive assistance, an employee's gross family income must be equal to or below 200% of the Federal Poverty Level. For a family of four, that is \$32,900 per year.

What kind of help is available for employees?

For people who have health insurance available through an employer, MassHealth may pay for all or part of the employees' premiums, depending on their income, the size of their family, and the cost of the insurance.

Is there any help available for employers?

The Commonwealth is launching a new program, called the Insurance Partnership, in January 1999. This program will provide financial assistance to small employers who offer and contribute to the cost of health insurance for their low-income employees. This will be phased-in, beginning with employers who purchase insurance through a participating intermediary (generally, employers with fewer than 10 employees).

What information is needed from employers?

- General information about the employer, including employer's name, address, and FEIN
- Whether or not the employer offers health insurance to employees
- If the employer offers insurance, some basic information about what is offered and what the cost is
- A copy of the Summary of Benefits for all of the policies that are offered

Why is this information needed?

The Division needs this information for the following reasons:

- To identify what insurance is available so we can determine the best way to assist eligible employees
- To determine whether or not the insurance offered meets the Division's test for comprehensiveness
- To determine the amount of assistance that can be provided to the employee and, whether or not assistance can be provided to the employer

What will happen to this information? Will others have access to it?

The information that you provide will be used only by the Division and its agents (entities which are under contract to the Division). It will be used only for the purposes of administering MassHealth programs and the Insurance Partnership.

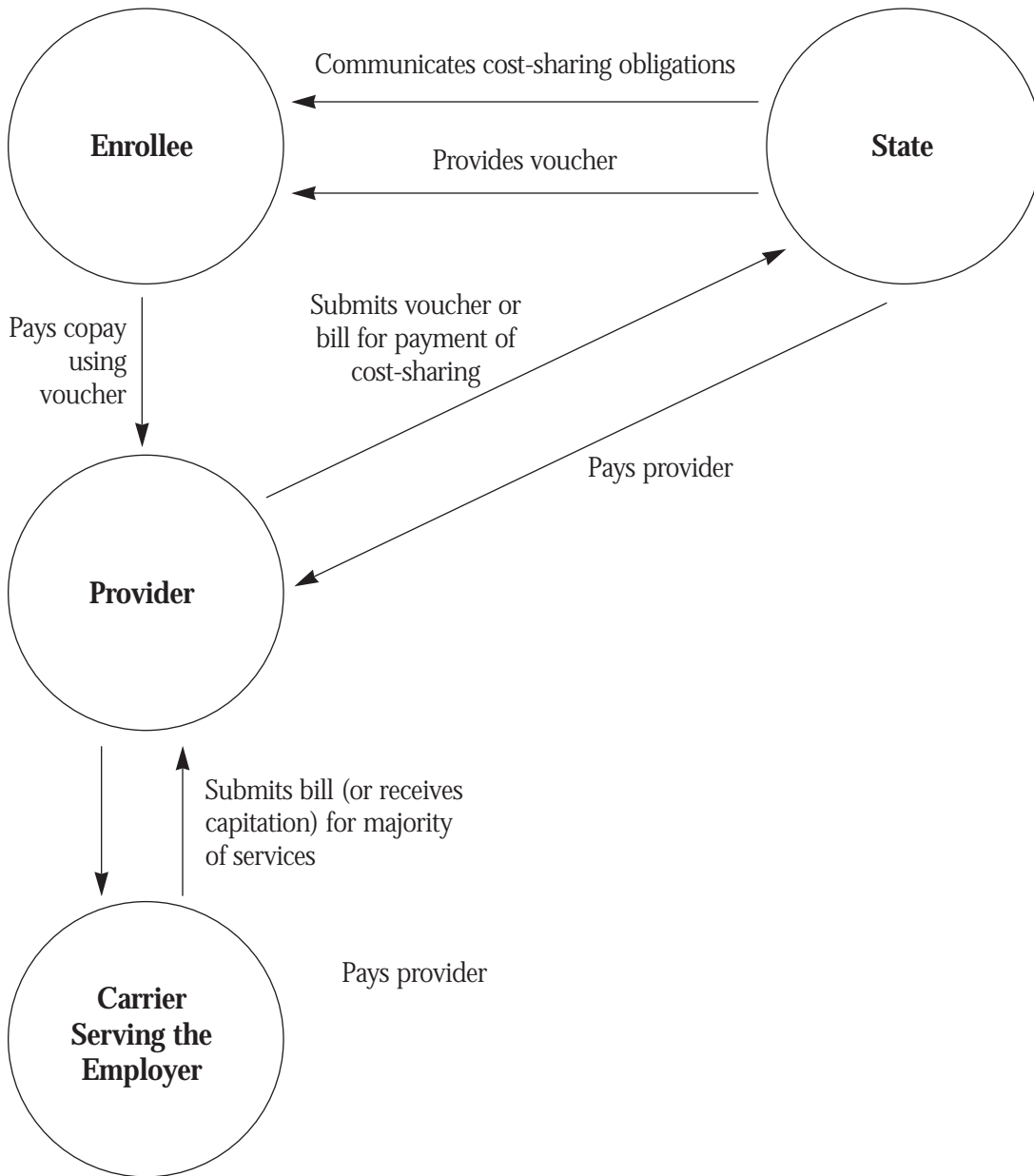
Is there a phone number to call for more information?

Please call a Family Assistance Insurance Coordinator at 1-888-291-4464.

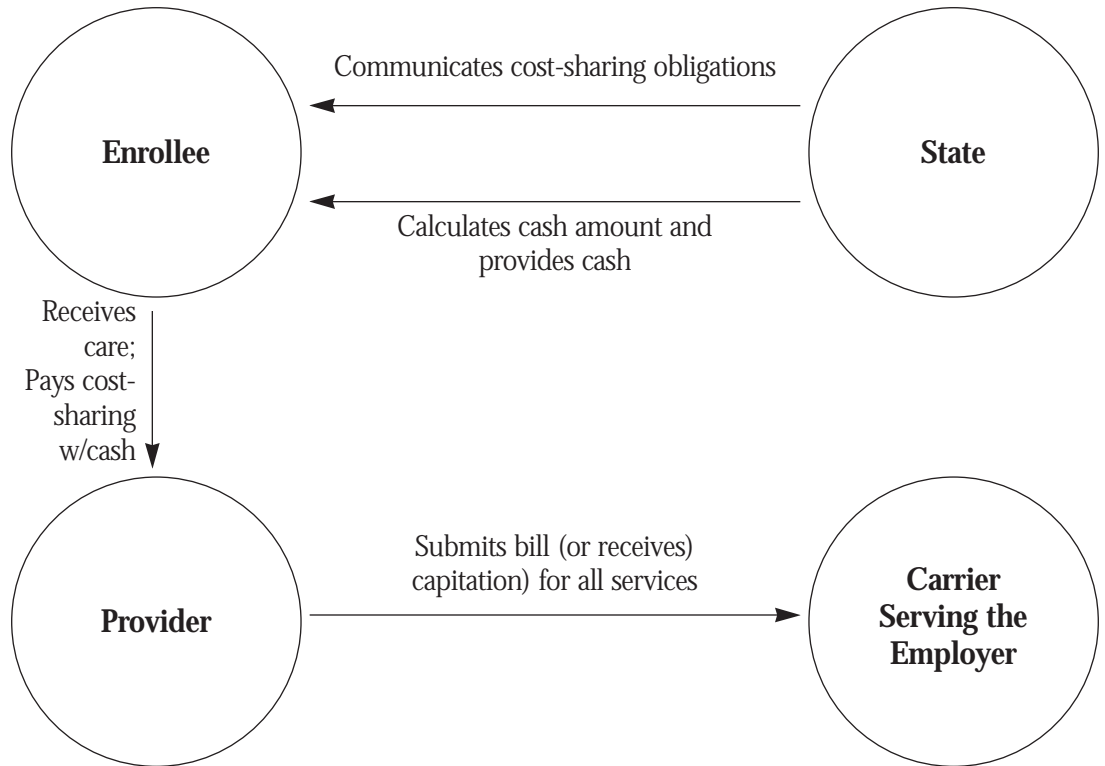
Appendix F:

Illustrations of Options for Supplementing Cost-Sharing Requirements⁶²

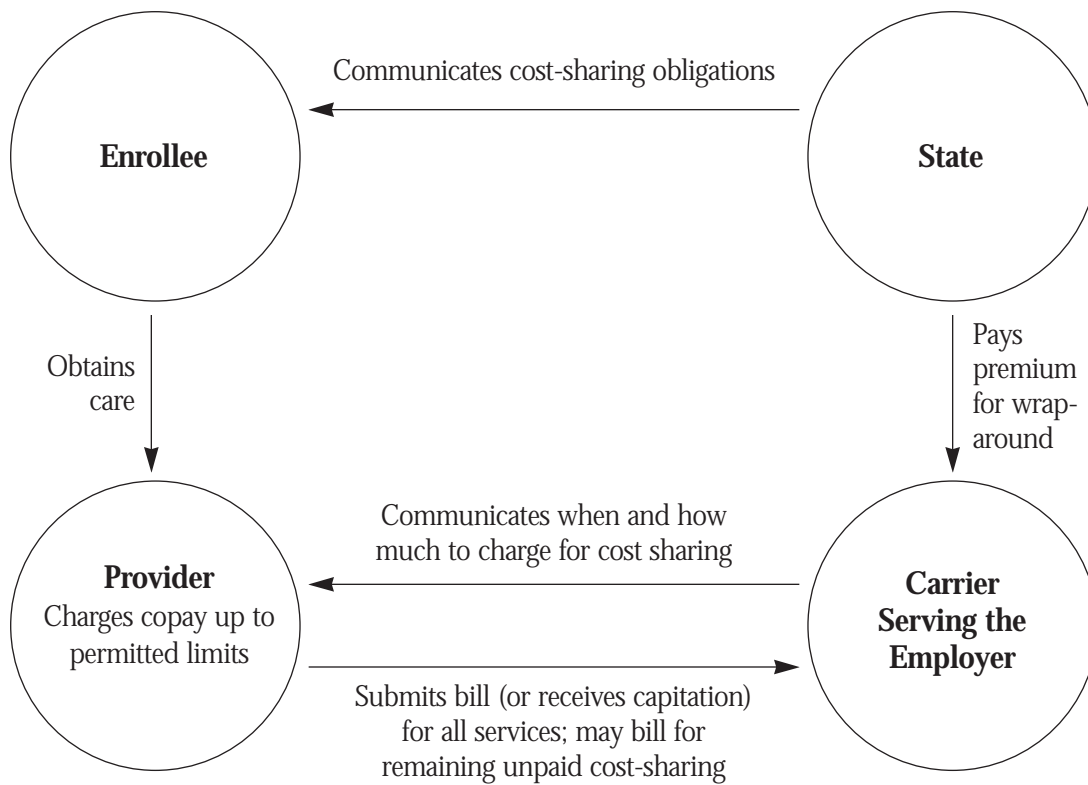
#1 Vouchers, or Provider-State Billing



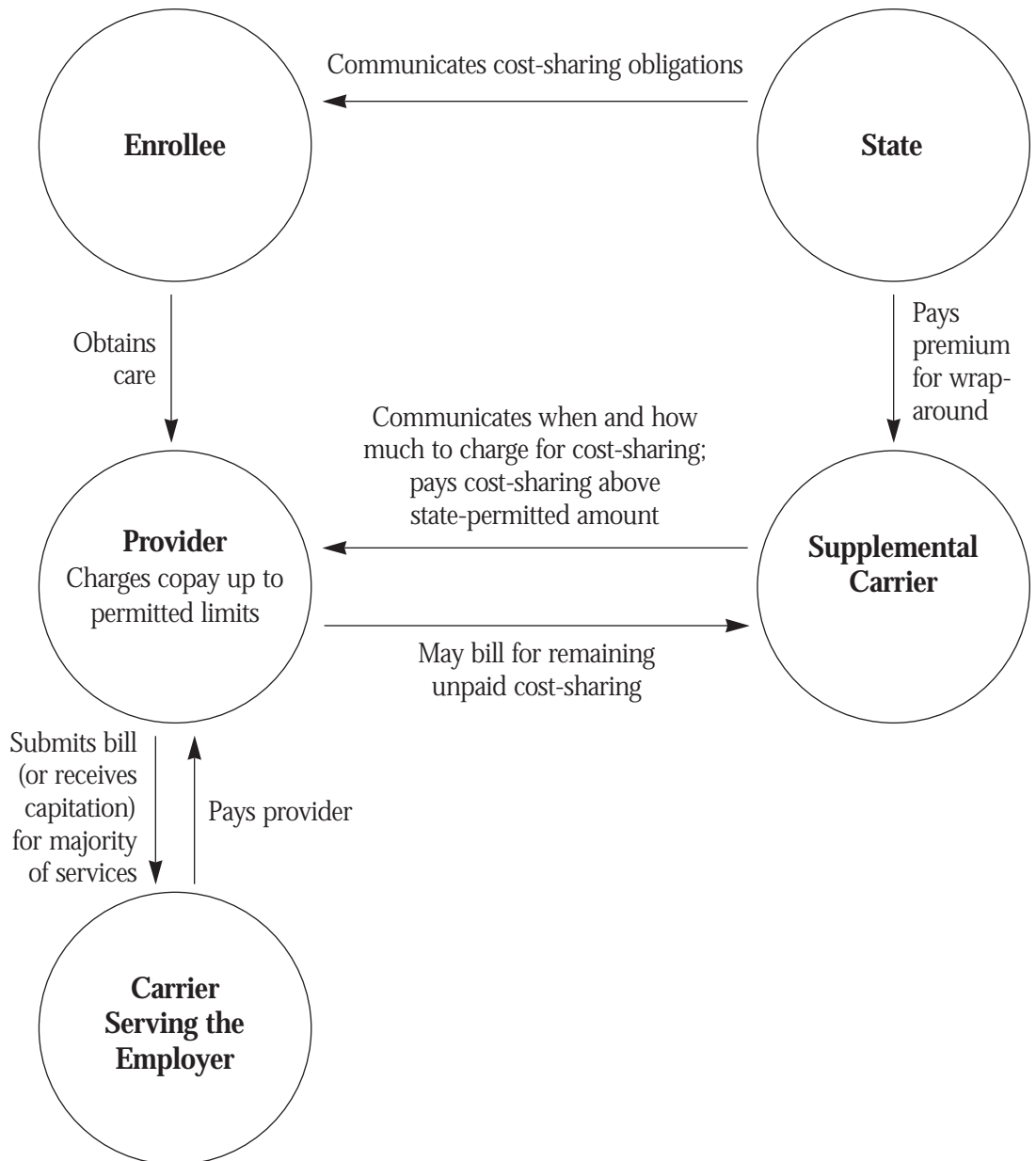
**#2
Cash**



#3 Carrier-Administered Wrap-Around



**#4
Supplemental Carrier**



Notes

¹ United States General Accounting Office, *Medicaid: Three States' Experience in Buying Employer-Based Health Insurance*, Report to the Chairman – Committee on Commerce – House of Representatives, Washington D.C., GAO/HEHS-97-159, July 1997 (available at: www.gao.gov/AIndexFY97/abstracts/he97159.htm).

² For more information on the difficulties states have encountered in implementing HIPP programs, see: Curtis, R. and A. Page, *Extending Health Care Coverage for Modest-Income Children and Pregnant Women: Public and Employer-Financed Coverage Lessons*, Institute for Health Policy Solutions, Washington D.C., December, 1996. To obtain this paper, call the Institute for Health Policy Solutions at (202) 857-0810.

³ Cooper, F and B. Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, V16, N6, 1997, pp. 142-149.

⁴ *Ibid.*

⁵ Pemberton, C. and D. Holmes, eds., *EBRI Databook on Employee Benefits*, Washington D.C., Employee Benefits Research Institute, 1995; and, U.S. Bureau of the Census, *Statistical Abstract of the United States*, Washington D.C., 1991 and 1996.

⁶ Analysis of the 1996 Medical Expenditure Panel Survey was performed by Mark Merlis of the Institute for Health Policy Solutions, funded by the David and Lucile Packard Foundation.

⁷ For a summary of the major provisions of the PRWORA, see: Super, D., S. Parrott, S. Steinmetz, and C. Mann, *The New Welfare Law*, Center on Budget and Policy Priorities, Washington, D.C., August 1996 (available at www.cbpp.org/WECNF813.HTM).

⁸ For more information about opportunities for states to provide family, rather than child-only, coverage, see: Cohan, S., *State Tools to Provide Family Health Insurance Coverage*, National Governors' Association Center for Best Practices, Health Policy Studies Division, Washington D.C., January 1999 (available at: www.nga.org/PUBS/IssueBriefs/1999/Sum990104SCHIP.asp).

⁹ Massachusetts received a Title XXI family coverage variance as part of a larger program that provides private coverage subsidies to both employees and employers under a state-wide, comprehensive Medicaid demonstration waiver (Section 1115).

¹⁰ For a description of programs in each of the Section 1115 waiver states, see the National Association of State Medicaid Directors (American Public Human Services Association) at: <http://medicaid.aphsa.org/1115waivers.htm>.

¹¹ For more information on state-only programs to provide health care services or insurance to low-income children and families, see: Gauthier, A. and S. Schrodell, *Expanding Children's Coverage: Lessons from State Initiatives in Health Care Reform*, Alpha Center, Washington D.C., May 1997 (available at: www.ac.org – see "On-Line Publication System").

¹² Selden, T., J. Banthin, and J. Cohen, "Medicaid's Problem Children: Eligible but not Enrolled," *Health Affairs*, V17, N3, May/June 1998, pp. 192 – 200.

¹³ A recent study by the Henry J. Kaiser Family Foundation sought to determine why some parents do not enroll potentially Medicaid-eligible children in the program. Researchers conducted eight focus groups of parents with children who were potentially eligible but not enrolled in Medi-Cal (California's Medicaid program). Most focus group participants cited the stigma associated with Medi-Cal as a major barrier to enrollment – stigma related to Medi-Cal's historical connection to welfare and welfare offices. Participants also believed that physicians and hospitals were likely to treat Medi-Cal recipients as "second class citizens." (Perry, J., E.

Stark, and R. Burciaga Valdez, *Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings from Eight Focus Groups in California with Parents of Potentially Eligible Children*, Henry J. Kaiser Family Foundation, Menlo Park, CA, September 1998.)

¹⁴ Private market insurance rating practices and their importance to a buy-in program are discussed in this Guide in section II(A)(3) - *Group or Individual Coverage: Understanding the State's Insurance Markets*.

¹⁵ Donelan, K., et al, *A Survey of the Health Insurance Status of Massachusetts Residents*, Department of Health Policy and Management, Harvard School of Public Health, Cambridge, MA, October 1995.

¹⁶ This letter is also available at <http://www.hcfa.gov/init/chsub213.htm>.

¹⁷ For a general overview of Oregon's program, see: Sexton, J., *An Overview of the Oregon Family Health Insurance Assistance Program*, Institute for Health Policy Solutions, for the David and Lucile Packard Foundation, Washington D.C., December 1998 (available at www.ihps.org/12-98Sex.htm).

¹⁸ Individuals must also be residents of Oregon, residents or documented non-citizens of the United States, have investment savings of less than \$10,000, and not be eligible for or receiving Medicare.

¹⁹ Federal match rates are higher under Title XXI than under Medicaid.

²⁰ For more information about BadgerCare, see: *Wisconsin Title XXI Amendment and Section 1115 Demonstration Fact Sheet*, Health Care Financing Administration, February 1999 (available at: www.hcfa.gov/init/chipwi.htm).

²¹ For an overview of the Massachusetts program, see: Hearne, J., *HHS Approves Massachusetts Premium Assistance for Employer-Sponsored Insurance*, Institute for Health Policy Solutions, for the David and Lucile Packard Foundation, Washington D.C., June 1998 (available at: www.ihps.org/Plan%20Approved.htm).

²² Data analysis was performed by Mark Merlis of the Institute for Health Policy Solutions under a grant from the David and Lucile Packard Foundation.

²³ Source: 1996 Medical Expenditure Panel Survey (MEPS). Because the MEPS does not provide information on total size of employer (but rather on size of establishment), the Institute for Health Policy Solutions used firm size/establishment size ratios of firms that reported offering coverage in the 1993 Robert Wood Johnson Foundation Employer Health Insurance Survey.

²⁴ Employer contributions to the cost of group health plans are a deductible business expense for the employer and are excluded from employees' income for the purpose of determining liability for income, Social Security, and Medicare payroll taxes. Self-employed workers who buy non-group (individual) coverage for themselves and their families may deduct part of the cost when determining their income tax (but not their Social Security or Medicare taxes). The deduction is limited to 60% of premiums in 1999 through 2001, 70% in 2002, and 100% percent in 2003. People who are not self-employed and who buy individual coverage do not have access to this deduction.

²⁵ For an annotated bibliography of crowd-out literature, see: Patchan, K. and J. Hearne, *Medicaid and Child Health Crowding Out: A Synopsis of Resources*, Institute for Health Policy Solutions, for the David and Lucile Packard Foundation, Washington D.C., December 1998 (available at: www.ihps.org/bibliography.PDF).

²⁶ Dubay, L. and G. Kenney, "Did Medicaid Expansions for Pregnant Women Crowd Out Private Coverage?" *Health Affairs*, V6, N1, January/February, 1997, pp. 185-193.

²⁷ Cutler, D. and J. Gruber, "Does Public Insurance Crowd Out Private Insurance?" *Quarterly Journal of Economics*, V111, N2, May 1996.

²⁸ Dubay, L., *Expansions in Public Health Insurance and Crowd-Out: What Difference do Different Approaches Make?* Background paper prepared for the Henry J. Kaiser Family Foundation Project on Incremental Health Reform, February 1999. (For a copy of this paper, contact Ms. Dubay at ldubay@ui.urban.org.)

²⁹ See Footnote 26.

³⁰ For a description of states' current crowd-out prevention policies (or "firewalls") in various public health insurance programs, see: Chollet, D., M. Birnbaum, and M. Sherman, *Deterring Crowd-Out in Public Insurance Programs: State Policies and Experience*, Alpha Center – State Initiatives in Health Care Reform, Washington D.C., October 1997 (available at: www.ac.org/httpdocs/crwd1097.pdf).

³¹ The following discussion of the MinnesotaCare program is largely excerpted from: Sexton, J., *MinnesotaCare and "Crowding-Out,"* Institute for Health Policy Solutions, for the David and Lucile Packard Foundation, Washington D.C., September 1998 (available at: www.ihps.org/9-98Sex.PDF).

³² Employer subsidized coverage is defined as a plan under which the employer pays at least 50% of the cost of coverage for the employee and dependents.

³³ Call, K., N. Lurie, Y. Jonk, R. Feldman, and M. Finch, "Who is Still Uninsured in Minnesota? – Lessons from State Reform Efforts," *Journal of the American Medical Association*, V278, N14, October 1997, pp. 1191-1195.

³⁴ The term "comparable" coverage is used here to indicate health coverage that meets the minimum level of benefits required under the MassHealth Family Assistance Program.

³⁵ See Footnote 16.

³⁶ All three states that have received approval for a Title XXI private coverage buy-in program (Mississippi, Massachusetts, and Wisconsin) intend to cover non-eligible family members when it is cost-effective. Of the three states, only Massachusetts has a family coverage variance. It is not clear, however, how Massachusetts' program differs from the other states' programs in this regard, perhaps because the other two states have not yet implemented the buy-in. Again, states are advised to consult the Health Care Financing Administration on this point.

³⁷ United States General Accounting Office, *Medicaid: Three States' Experience in Buying Employer-Based Health Insurance*, Report to the Chairman – Committee on Commerce – House of Representatives, Washington D.C., GAO/HEHS-97-159, July 1997 (available at: www.gao.gov/AIndexFY97/abstracts/he97159.htm).

³⁸ However, ERISA does not apply to health benefit plans, either fully-insured or self-insured, that are established and maintained by governmental entities or churches.

³⁹ United States General Accounting Office, *Medicaid: Three States' Experience in Buying Employer-Based Health Insurance*, Report to the Chairman – Committee on Commerce – House of Representatives, Washington D.C., GAO/HEHS-97-159, July 1997 (available at: www.gao.gov/AIndexFY97/abstracts/he97159.htm).

⁴⁰ Until 1997, health benefit plans were required to file Summary Plan Descriptions with the U.S. Department of Labor. That requirement was repealed under the Taxpayer Relief Act of 1997. Consequently, states are now unable to access information about an employer's plan through public records.

⁴¹ Personal communication with MassHealth officials, February 1999.

⁴² Portions of this section are excerpted from: Tollen, L., *Coordination of Title XXI Coverage with Employer-Based Coverage through Consumer-Choice Health Purchasing Groups*, Institute for Health Policy Solutions, Washington D.C., January 1999. Much of the information included in this paper was gathered at a series of round-table discussions, facilitated by the Institute for Health Policy Solutions, including Title XXI state program officials, insurance carriers, third

party administrators, purchasing groups, and others. These round-table discussions were made possible by the David and Lucile Packard Foundation.

⁴³ See 42 Code of Federal Regulations (CFR) 440.210.

⁴⁴ See 42 CFR 447.50 – 59.

⁴⁵ Title XXI permits states to choose a “benchmark” plan from among three options: a) the commercial plan in the state with the largest enrollment; b) the state employee plan with the largest enrollment; or c) the Federal Employees Health Benefits Plan PPO option. Coverage under Title XXI, whether provided through a public program or a private coverage buy-in program, must be at least actuarially equivalent to the benchmark.

⁴⁶ States can prove actuarial equivalence by showing that an employer-based plan covers all the required benefits at (or above) the minimum levels. To meet this actuarial equivalency test, *each* benefit must be covered at the required level. As an alternative, states can show that *overall*, the value of an employer-based plan is at least equivalent to the benchmark. While this method is more complicated than the benefit-by-benefit comparison, it has the advantage of allowing states to “make up” for deficiencies in the coverage of one benefit with excess coverage of another benefit. For example, if the outpatient surgery benefit does not meet the benchmark standard but the inpatient hospital benefit exceeds the standard, states can balance the two benefits against each other to show that the overall value of the plan is at least actuarially equivalent to the benchmark.

⁴⁷ See Section II(A)(3) of this Guide – *Group or Individual Coverage: Understanding the State’s Insurance Markets*.

⁴⁸ Coordination of buy-in programs with consumer-choice health purchasing groups is discussed in section II(B)(5) of this Guide.

⁴⁹ This analysis, funded by the David and Lucile Packard Foundation, was performed using data from the 1996 Medical Expenditure Panel Survey (MEPS). The data are for all children, rather than for children in the Title XXI-eligible income levels, as the MEPS does not include income data. The analysis assumes utilization of services by children in the Title XXI-eligible income range is the same as utilization of services by all children.

⁵⁰ Tollen, L., *Coordination of Title XXI Coverage with Employer-Based Coverage through Consumer-Choice Health Purchasing Groups*, Institute for Health Policy Solutions, for the David and Lucile Packard Foundation, Washington D.C., January 1999 (available soon at www.ihps.org or by calling (202) 857-0810).

⁵¹ Note this that approach will not work when the employer-based plan features a closed network of capitated providers, such as a group model HMO. In such situations, the overlap between the employer-based plan’s network and the Medicaid network is likely to be small. This approach to filling-in participant cost-sharing would likely work more smoothly in situations where the employer-based plan features an open network (e.g., a PPO or indemnity plan).

⁵² Portions of this section are excerpted from: Tollen, L., *Coordination of Title XXI Coverage with Employer-Based Coverage through Consumer-Choice Health Purchasing Groups*, Institute for Health Policy Solutions, for the David and Lucile Packard Foundation, Washington D.C., January 1999. See Footnote 42.

⁵³ Personal communication with Oregon Health Plan Administrator’s Office, March 1999.

⁵⁴ For more information about consumer choice health purchasing groups, see the Institute for Health Policy Solutions web site at www.ihps.org/CHPGs.html.

⁵⁵ The Academy of Consumer-Choice Purchasing Groups is largely funded by the John A. Hartford Foundation. For more information, call the Institute for Health Policy Solutions at (202) 857-0810, or see: www.ihps.org/CHPGs.html.

⁵⁶ Guyer, J. and C. Mann, *Taking the Next Step: States Can Now Expand Health Coverage to Low-Income Working Parents Through Medicaid*, Center on Budget and Policy Priorities, Washington D.C., August 19, 1998 (available at <http://www.cbpp.org/702mcaid.htm>).

⁵⁷ *Ibid.* Excerpt used with permission of the authors.

⁵⁸ The HCFA letters can be found at www.hcfa.gov/medicaid/wrefhmpg.htm (see: "Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World," 3/22/99; and, "Regarding Implementation of Section 1931 of the Social Security Act," 9/22/97).

⁵⁹ This requirement is found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Prior to the passage of HIPAA, several states already had similar laws on the books.

⁶⁰ The federal Health Insurance Portability and Accountability Act requires such limitations on pre-existing condition waiting periods for all group health plans.

⁶¹ Those who are rejected by an individual insurance carrier for health reasons are eligible for the state-administered high-risk pool.

⁶² These illustrations are excerpted from: Tollen, L., *Coordination of Title XXI Coverage with Employer-Based Coverage through Consumer-Choice Health Purchasing Groups*, Institute for Health Policy Solutions, for the David and Lucile Packard Foundation, Washington D.C., January 1999. See Footnote 42.

